IN CIRCUIT COURT OF THE FIFTEENTH JUDICIAL CIRCUIT IN AND FOR PALM BEACH COUNTY, FLORIDA

CASE NO. 2012CA020960XXXXMBAA

DOMINIC J. SHELTON, a minor, by and through his parents and natural guardians, HEATHER MCCANTS and BILLY SHELTON, and HEATHER MCCANTS and BILLY SHELTON, individually,

Plaintiffs,

-vs-

BERTO LOPEZ, M.D.; LISA M. SANCHES, M.D.; OB GYN SPECIALISTS OF THE PALM BEACHES, PA; KERRY S. LANE, M.D.; ANESTHESIA AND CRITICAL CARE SPECIALISTS OF PALM BEACH, PA; TENET ST. MARY'S INC. D/B/A ST. MARY'S MEDICAL CENTER, a Florida corporation,

Defendants.

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CONTINUATION VIDEOTAPED DEPOSITION OF BERTO LOPEZ, M.D.

TAKEN ON BEHALF OF THE PLAINTIFFS

Thursday, October 17, 2013
10:06 a.m. - 2:13 p.m.

515 N. Flagler Drive
Suite 1701
West Palm Beach, Florida 33401

Reported By:
Kathleen Lusz, RPR
Notary Public, State of Florida
Job#3969

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ALSO PRESENT:

Anthony Barbaro, Videographer

I N D E X

- - -

VOLUME I

VOLUME II

E X H I B I T S M A R K E D

- - -

CONTINUED VIDEOTAPED DEPOSITION OF BERTO LOPEZ, M.D.

OCTOBER 17, 2013

- - -

THE VIDEOGRAPHER: Today's date is October 17, 2013. The time on the video monitor is 10:06 a.m.

MR. SILVA: Swear the witness.

Thereupon,

BERTO LOPEZ, M.D.,

having been first duly sworn, was examined and testified as follows:

DR. LOPEZ: I do.

CONTINUED DIRECT EXAMINATION

BY MR. SILVA:

Q. Good morning. This is a continuation deposition from August 9, 2013.

I want to clarify a couple things at the outset. If you recall, we were discussing your discharge summary, which I've previously marked as Plaintiff's Exhibit Number 2. And I asked you some questions about whether you had signed this form or not. And I believe you testified that you had not signed it; do you recall that?

A. Yes, that's correct. I did not put a wet signature on this form.

Q. Okay. Now, I want you to look at the very

bottom of this page where it says authenticated by Berto Lopez on February 26, 2011 at 12:48 in the afternoon. Do you see that?

A. Yes.

Q. Is that considered an electronic signature --

A. Yes.

Q. -- at St. Mary's Medical Center?

A. It's considered an electronic authentication, correct.

Q. Okay. I'll take that.

I'm going to mark now what will be Plaintiff's Exhibit Number 14.

(Plaintiff's Exhibit Number 14 was marked for identification.)

BY MR. SILVA:

Q. Take a look at it. And can you identify that document for me, sir?

A. Other than Exhibit 14, I'm not familiar with this document.

Q. Okay. What's -- What's the title at the top of the page?

A. It says on the top left OnGuard 2013. Access denied, granted and other badge events.

Q. And who is that information for?

MS. WIDLANSKY: Form.

BY MR. SILVA:

Q. Does that have your name on it?

A. On the right section it says cardholder name, it has details, event, date/time and device.

Q. Is your name anywhere on that form?

A. Yes, as the cardholder. Cardholder name is my name.

Q. Berto Lopez?

A. Yes.

Q. Okay. And it appears here that at 3:30 in the afternoon access was granted to the physicians' east lot; do you see that?

A. Yes.

Q. And can you describe how you get access to this hospital with regards to parking in the physicians' parking lot? Do you have to use some sort of card or an access code?

A. Yes. We use an identifying badge. And I mean even though it may be from another hospital, they're somewhat similar. I think I still have one from this morning.

Yeah. Here is my St. Mary's access badge. It has a magnetic strip. And I generally park in the east physicians' parking lot which faces Greenwood Avenue.

And in order to be -- There is an automatic

wooden arm that goes down. You have to swipe your badge into a magnetic reader. And then if you're identified and approved, the arm goes up, you park your car, and you go inside --

Q. Okay.

A. -- the hospital.

Q. Okay. Do you use that same card to access the Good Samaritan physicians' parking lot?

A. The St. Mary's parking lot.

No, you use a different one for Good Sam.

Q. Okay.

A. This one is for St. Mary's.

Q. It's specifically for St. Mary's?

A. Yes. Each hospital has their own badge.

Q. Okay. And so on that day when you were called to come to the hospital for Heather McCants, you would have came to the east physicians' parking lot?

A. Correct.

Q. And then you would have swiped your card?

A. Yes.

Q. And is that what this document shows that you swiped your card at 3:30 in the afternoon?

MS. WIDLANSKY: Object to the form.

THE WITNESS: That's what it appears to say, yes.

BY MR. SILVA:

Q. Okay. And then after that the next time entry on this document states that 13 OB in R/0-3-14-2 access granted to Berto Lopez.

Do you know what that stands for? Would that be --

A. At 3:30 p.m.?

Q. Yes, sir.

A. That appears to be 13 OB into R/0-3-14-2 access granted. While I cannot say with certainty, because I'm not involved with the badge system at St. Mary's, it's probably when I badged into the labor and delivery unit, the doors by the elevator --

Q. Okay.

A. -- to get into the labor and delivery area.

Q. Okay. And I guess my next question is going to be once you park your car in the east physicians' parking lot at St. Mary's Medical Center, how do you gain access to the hospital normally?

A. I go in through the Greenwood Avenue entrance, walk in, passed the security checkpoint which is not badged --

Q. Okay.

A. -- go to a bank of elevators. And the entrance is on the ground floor. So you hit one to go

to the first floor, which is where labor and delivery is in. And then I would badge into access controlled doors that allow me into the labor and delivery area.

Q. Okay. And then there is an entry here at 3:37 p.m. that also says 13 OB R/0-3-14-2. Can you tell us why this system would have captured your badge again at 3:37?

MS. WIDLANSKY: Form.

THE WITNESS: And, again, I'm not an expert on what this form stands for.

But I re-badged in, as I mentioned before, I went to the elevator bank after waiting for Ms. McCants to be brought down from the second floor, the antepartum area, to the first floor where the OB/OR is. I walked to the bank of elevators.

BY MR. SILVA:

Q. I gotcha.

A. And then I re-badged into the OB/OR preop area.

Q. Okay. So that would explain a badging into the L&D area at 3:33 and then a second reentry at 3:37, approximately four minutes later?

A. That's right.

Q. Okay. And then the next time that access was

granted appears to be OB out at 4:15 in the afternoon?

A. Yes.

Q. Is that the time that you would have left the facility?

A. That would have been my badging out of the OB delivery area, which would include the OB/OR area, to go back to the bank of elevators to go back to the first -- the ground floor to go out to the parking lot to go to my car.

Q. Okay.

A. At least that's my interpretation of that.

Q. Does that -- Does this document help refresh your recollection of what happened that day?

A. Only I would say it's an independent record electronically of my badging in and badging out behavior if that is, in fact, certified as the hospital's badging record.

Q. Okay. Did you -- As you sit here today, do you know if you ever looked at the electronic medical records for the nurses notes for Heather McCants on January 26, 2011?

A. No, I did not.

Q. Okay. I'm going to have you take a look at what I'm going to mark as Plaintiff's Exhibit Number 15.

(Plaintiff's Exhibit Number 15 was marked for

identification.)

BY MR. SILVA:

Q. Prior to this case, have you had occasion to look at electronic nurses notes at St. Mary's Medical Center?

A. Yes.

Q. Okay. Does that look familiar to you as entries that nurses make into the medical record?

A. Yes.

Q. Okay. And according to this first page on Plaintiff's Exhibit Number 15, is there a timed entry there for a nurses note on January 26th at 12:15 in the afternoon?

A. Yes.

Q. And it says call for PICC Team, no answer. Do you see that?

A. Yes.

Q. Were you involved in any of the issues with the PICC line being clotted prior to your call from the Rapid Response Team?

A. No.

MS. WIDLANSKY: Form.

BY MR. SILVA:

Q. Then at 12:40 there is a nursing entry here that states: Left message for the PICC Team. Do you

see that?

A. Yes.

Q. Okay. Turn to the next page, please.

At 1:00 in the afternoon on January 26th there's a nursing entry: Notified Carol Seamon that PICC Team was has not answered. Do you see that?

A. Yes.

Q. Did you ever have any conversations with Nurse Carol Seamon regarding any of the issues of the PICC line being occluded?

A. No, not that I can recall.

Q. Okay. Or any issues with them having difficulty in getting the PICC line team to come address the occluded PICC line?

A. No.

MS. WIDLANSKY: Form.

BY MR. SILVA:

Q. The next entry in this nurses note that you're looking at is January 26th, 2:40 in the afternoon, and it says: Call to Patrick, PICC Team.

Do you know a Patrick on the PICC Team at this hospital?

A. I don't personally know of Patrick. I have I believe spoken to Patrick on the PICC line team. He's a nurse that does line placements.

Q. Okay. Do you have occasion to order PICC lines on your patients occasionally at this hospital?

A. Yes.

Q. And how do you go about doing that?

A. Generally speaking -- Well, it's kind of a then and now. Back then you would write the order. Or if you wanted it with some sort of expeditious response, you would call for the PICC line nurse and then speak to them and explain to them what your needs were. And then they would express how they were going to satisfy those professional needs.

Q. Okay. When you ordered a PICC line for a patient, do you recall if there is a specific protocol on the chart back in 2011 that you had to fill out with regards to the maintenance of the PICC line?

A. Since it's 2011 and we're talking about 2013, I don't remember specifically.

Q. Okay. The next entry is at on this electronic nurses note 3:05, and it states: Patrick at the bedside administered Cathflo in both PICC ports.

My question to you is after this incident occurred, did you have any conversations with any of the health care providers as to why the Cathflo needed to be injected at 3:05 on January 26th?

MR. MITTELMARK: Object to the form.

BY MR. SILVA:

Q. Go ahead.

A. I don't recall specifically. I know that I never spoke to Patrick. I remember having a conversation with Nurse Duckworth. And my understanding was that the PICC line had occluded, and they were going to flush them as they do routinely if there is an occluded PICC line.

Q. Okay. Was that in the initial conversation that you had with Janis Duckworth on the phone?

A. Yes. And that would have been like after the rapid response --

Q. Okay.

A. -- had occurred.

Q. Okay. You didn't have any conversations with Janis Duckworth on that date prior to the Rapid Response Team being called?

A. That's correct. Because Dr. Tum, as was indicated in one of these notations, made rounds in the antepartum patients for our group.

Q. Okay. Do you know if Dr. Tum was still in the hospital at the time that the Rapid Response Team was called?

A. No, I don't.

Q. Do you know if Janis Duckworth attempted to

call Dr. Tum prior to you being called on January 26, 2011?

A. I don't know.

Q. The next entry in this electronic nurses note is at 3:06. It states: Patient complains of shortness of breath immediately following Cathflo administration.

Is that your understanding of what Janis Duckworth told you that this patient had an immediate reaction to the Cathflo injection?

A. Or something --

MR. MITTELMARK: Object to the form.

BY MR. SILVA:

Q. You can answer.

A. Or something consistent with that. I don't remember exactly what she said.

Q. I'll take that one. Thank you.

Next I'm going to mark Plaintiff's Exhibit Number 16, which is the perioperative nursing note.

(Plaintiff's Exhibit Number 16 was marked for identification.)

BY MR. SILVA:

Q. Just take a look at that, sir. And then I'm going to ask you some questions.

Whenever you're done, just let me know.

A. Okay. I'm ready.

Q. Okay. Back on January 26, 2011 were physicians notes at this hospital and progress notes and physicians orders in paper form?

A. Yes.

Q. Okay. Did you as a physician, as an OB/GYN, ever enter any information into the electronic medical record back in January of 2011?

A. Not to my recollection.

Q. So what we're looking at here is a perioperative nursing note. It appears the author is Josephine Braga. It's in electronic form.

Do you know who entered this information into this document?

A. Know by independent knowledge, no. But I would assume since it's been recorded as Josephine Braga, stored by the Josephine Braga, RN, on the top left of the page that she was an author of the note.

Q. And it has an area here where it says last stored at 4:21 on January 26th. Do you see that?

A. Yes.

Q. Is there any indication on this form that would lead you to conclude that any entries were made at 6:23 in the afternoon on January 26th to this record?

MR. MITTELMARK: Object to the form.

MS. WIDLANSKY: Form.

BY MR. SILVA:

Q. You can answer.

A. No.

Q. Okay. The -- According to this document it states: Transported to OR: Bed. Does that -- What does that mean, that she's transported in the same bed she was in?

A. Yes. As opposed to a stretcher.

Q. Okay. And then transport by RN.

Does it identify which RN transported the patient?

A. No.

Q. It says that OR room number two. Does that refer to the OB/OR or the main OR?

A. This is the OB/OR. There is two OB/ORs: Room one and room two. This case occurred in room two.

Q. Okay. And then next case type it has urgent.

A. Correct.

Q. Do you see that?

Do you know who directed Josephine Braga to enter a case type urgent in this form?

MS. WIDLANSKY: Form.

THE WITNESS: Probably me.

BY MR. SILVA:

Q. And it says scheduled OR time: Patient in the

OR at -- Is that 1537?

A. That's what I interpret that as, yes.

Q. Okay. So that would be in laymen's terms 3:37 in the afternoon?

A. Yes.

Q. As you sit here today, do you know where Heather McCants was from the time that the C-section was called until 3:37?

A. In a general way I knew that she was in her room. Then she was transported down the hallway, took elevators down from the second floor to the first floor, and then was brought to the preop area in front of the operating rooms before she was wheeled into the operating room.

Q. Okay. Have you ever used your cell phone in an OB operating room at St. Mary's Medical Center?

A. No.

Q. Have you ever attempted to?

A. Yes, but the reception was unacceptable.

Q. Okay.

A. I have AT&T. I don't know if it's any better with somebody else.

Q. Okay. So your cell phone carrier is AT&T?

A. Yes.

Q. Have you attempted to make a cell phone call

from your AT&T cell phone prior to today in either one of the OB/ORs at St. Mary's Medical Center?

A. Not in -- Not to my recollection. But things have changed. I mean, you know, now they've upgraded to a 4G system, whatever that means, and then a 4G LTE.

So I don't know what type of system, meaning how many towers and what the strength of the signal was. But --

Q. Sure.

A. -- prior to approximately 2011, it wouldn't go through. Phone messages and text messages wouldn't go through, phone calls wouldn't go through.

Q. Okay. Do you know if the OB operating rooms are leaded?

A. No, I don't know that.

Q. Okay. Do you perform x-rays in the operating room?

A. Sometimes.

Q. According to this document, the anesthesia start time and date is January 26, 2011 at 3:37. Do you see that?

A. Yes.

Q. And then the incision time according to this document is at 3:51?

A. Yes.

Q. And the preop diagnosis was fetal, nonreassuring status?

A. Yes.

Q. Do you know how Josephine Braga -- where she got that knowledge to put that information into this document?

MS. WIDLANSKY: Form.

THE WITNESS: Not exactly, no.

BY MR. SILVA:

Q. Do you know if that was an assessment she made herself or if a physician directed her to put that preop diagnosis in?

A. I would be speculating. I think we could ask Nurse Braga.

Q. Okay. As an OB/GYN what does a fetal nonreassuring status mean; do you know?

A. It means that the baby is in an environment that it needs to be taken away from. In other words, the baby is inside the mother's womb, and it's not demonstrating the signs of fetal well-being such that it needs to be removed by operation.

Q. It means the operation, the C-section?

A. Cesarean section, yes. C-section.

Q. And then the postop diagnosis, was that the same: Fetal, nonreassuring status?

A. Yes.

Q. What -- What's the reason for entering in -- this information into the medical record preop where it says postop diagnosis?

A. First of all, documentation of the reason or indication for surgery is a standard nursing documentation obligation, both for billing and coding and for the health care processes to be understood by other members of the health care team.

And postop diagnosis, sometimes it matches up with the preop, sometimes it doesn't depending on the circumstances.

Q. Okay. In this case the postop diagnosis was still fetal, nonreassuring status, correct?

A. Yes.

Q. And then the operation, what is documented here?

A. Non-scheduled primary cesarean.

Q. Okay. And that -- that's to distinguish this surgery from a scheduled primary cesarean section?

A. Correct.

Q. And a scheduled primary cesarean section would be something that's planned ahead of time with the patient and the physician and the staff?

A. Correct. It's a scheduled, planned C-section.

You have an appointment to have your baby delivered.

Q. And then the anesthesia type used states spinal Astramorph?

A. Yes.

Q. What does that mean to you as an OB?

A. It's a subarachnoid injection of medication called Astramorph, which is long-acting pain medication that's administered to alleviate pain and discomfort for about 24 hours.

Q. The surgeon is yourself, right?

A. Yes.

Q. And this documents that you came into the room at 3:50?

A. Yes.

Q. And that you left at 4:05?

A. Yes.

Q. And then it states that there were some assistants there, a Milsa Amely?

A. Yes.

Q. Does she or he work with you?

A. She is a registered nurse first assistant who has assisted me on hundreds of cesarean sections.

Q. Is she a hospital employee?

A. She is.

Q. And then underneath that there is Dr. Tum. Do

you see that?

A. Yes.

Q. It states that these two providers came into the room also at 3:50?

A. Yes.

Q. Do you see that?

A. Yes.

Q. Is that your recollection, that Dr. Tum came into the room at the same time you did?

A. No. Initially Dr. Tum was in transit to the hospital so -- As I recall. And Milsa Amely, Nurse Amely, assisted me until Dr. Tum arrived.

Q. Did Dr. Tum arrive before or after the baby was delivered?

A. That I don't recall.

Q. You were able to get the baby out in one minute from the time that the procedure started, right?

A. If that's what the record indicates. You know, when you're actually performing these things, you're -- I'm not the one documenting times. I'm more interested in taking care of the patient.

Q. In a -- in a stat C-section can you get a baby out in a minute once you start the procedure?

A. Theoretically if it was a stat C-section, yes.

Q. Okay.

A. But I also routinely in a scheduled C-section would get a baby out in about the same amount of time. My technique is called the -- It's a Swedish method where I use blunt dissection rather than sharp dissection. And I don't do anatomic separation of peritoneal surfaces such as the abdominal peritoneum and the parietal peritoneum.

Q. And what -- Do you know what kind of --

Do you recall what kind of a surgical approach you used? Did you use a vertical incision or --

A. No. I used a low transverse incision.

Q. Okay. According to this document, did you have any difficulty in delivering the baby once you started the procedure?

A. According to this document, it doesn't indicate one way or the other. But I don't recall any technical factors other than, as I mentioned before, Ms. McCants was 350 pounds and five foot maybe two. And I believe her abdomen had to be taped up in the manner which they typically do when patients have a -- what we call a panniculus, which is -- which is abdominal drape of -- of skin that would cover over the typical incision site.

Q. Sure. But if these medical records state that the incision time started at 3:51 and the baby was

delivered at 3:52, would you have any reason to dispute that?

A. No.

MS. WIDLANSKY: Form.

BY MR. SILVA:

Q. The doc -- This document states that the anesthesiologist, Kerry Lane, came into the room at 3:57. Do you see that?

A. Yes.

MR PUYA: Object to the form.

MR. SILVA: And --

MR PUYA: 3:57?

MR. SILVA: Strike that.

BY MR. SILVA:

Q. This document states that anesthesiologist, Kerry Lane, came into the room at 3:37?

A. I stand corrected as well, yes.

Q. Yes, thank you.

And it states that you left the room at 4:00?

A. Yes.

Q. Do you know if there were any other anesthesiologists in the room from 4:00 until 4:05, until the time that you left the room?

A. I do not know from recollection.

Q. Okay. Does this document show that any CRNA

was in the room from 4:00 until 4:05?

A. Since I'm not the author of this article -- I'm sorry, of this document, I don't see an indication that there was.

Q. Well, there is an area there for CRNA. Is that blank?

A. Yes.

Q. And then it has circulator, Josephine Braga, time in the room at 3:37?

A. Yes.

Q. And do you know a Nurse Braga?

A. Yes.

Q. And it appears Barbara Akan also came into the room at 3:37. Do you know that nurse?

A. Yes.

Q. And what about Marie Taylor?

A. Yes.

Q. She came into the room also at 3:37?

MS. WIDLANSKY: Form.

THE WITNESS: That would -- I have no recollection. I'm not the author of this note.

BY MR. SILVA:

Q. But according to this document?

A. Yes. According to this document, that's what it says.

Q. Do you recall -- Do you know a Marie Ambroise?
A. Yes, Dr. Ambroise.
Q. What kind of doctor is she?
A. I'm told she's a pediatrician who specializes in neonatologist.
Q. Do you recall --
A. Neonatology, excuse me.
Q. Do you recall if she was in the room at the time that the baby was delivered?
A. I don't know. Because, again, I was doing what I was doing and not really clocking in and seeing -- I was not the author of this note so I cannot say one way or the other if -- if she was in the room as indicated or not.
I do remember that she was in the room when the baby was born.
Q. Do you know what time these entries were put into this electronic medical record?
A. No.
Q. Do you know if Josephine Braga met with Risk Management before she entered these times into this document?
A. No.
Q. I'll take that. Thank you.
Next document I'm going to have you look at is

a cesarean section preop order, which I'm going to mark as Plaintiff's Exhibit Number 17.

(Plaintiff's Exhibit Number 17 was marked for identification.)

BY MR. SILVA:

Q. Can you identify this document for me?

A. Yes. This is a preop order sheet, which is a standardized order sheet.

Q. Is this a physician's order sheet that has to be filled out and signed --

A. Yes.

Q. -- prior to any surgical procedure?

A. Yes.

Q. And is your writing anywhere on this document?

A. Yes. The date and the signature are my writing.

Q. Okay. And do you see an area there where it says date, forward slash, time?

A. Yes.

Q. And did you time this document?

A. No, I did not.

Q. Do you know at what time you signed this document?

A. No, I do not.

Q. Can you tell me what your preop orders were?

A. They are as indicated on this page, including the check mark for the CBC and the 2 grams of IV Ancef push to be --

If you want me to run -- Do you want me to run through every one of the orders?

Q. Well, yeah, you can start from the top and go on.

A. Okay. Number one was admit to inpatient status.

Number two was NPO.

Number three, IV Lactated Ringers at 150 milliliters per hour.

Number four, CBC, type and screen.

Number five, medications: Ancef, which is cefazolin, two grams IV, one dose before OR.

Number six, clip and prep in operating room at surgeon's discretion.

Number seven, number 16 Foley with five milliliter balloon. Patient may request placement in OR.

Number eight, check for consent. If not present, please place one on front of chart.

Number nine, Alka Seltzer Gold two tabs PO in 30 milliliters of water or Bicitra 30 milliliters preop times one.

Number ten, anesthesia to preop.

Number eleven, sequential compression devices to OR.

Q. Okay. Do you know if these -- If your orders were actually carried out prior to the procedure?

A. I believe they were.

Q. Do you know when the CBC was ordered and drawn?

A. Since she was an inpatient being monitored for prolonged rupture of membranes, I don't know whether one was done specifically that day. But she was having them done serially.

Q. Okay. But your order was to perform a CBC, right?

A. Correct.

Q. Do you know if the nurses performed it?

A. No, I don't. I don't have independent recollection.

Q. Okay. You also had an order to give Ancef two grams IV one dose before the operating room. Do you know if the nurses did that?

A. I do not know.

Q. What was your reason for ordering Ancef two grams IV one dose before the OR?

A. There were several. The main reason is it's a

prophylactic antibiotic to diminish the risk of a surgical site infection.

Q. Do you know how long it takes to administer two grams of IV of Ancef?

MS. WIDLANSKY: Form.

THE WITNESS: I don't know like in minutes and seconds, but it doesn't take very long.

BY MR. SILVA:

Q. Have you ever read the product insert for cefazolin?

A. Probably not since it came out.

Q. Would you disagree with any of the product recommendations on the product insert for the antibiotic?

MS. WIDLANSKY: Form.

MR. MITTELMARK: I'll join.

THE WITNESS: You mean specifically in regards to Ancef or in general? Since --

BY MR. SILVA:

Q. No in --

A. -- one of my former professors was on the FDA committee for medications. I can tell you that many of the items that are included in the product insert are boilerplate and are the same across the board for many medications and do not necessarily reflect the usage of

a medication at the time of a clinical situation.

In other words, when they're passed -- When a drug is approved by the Food and Drug Administration, the product insert is approved by the Food and Drug Administration and the regulators thereof. And they're only updated periodically. So the product insert may be several years old relative to the advancement of how we practice medicine.

Q. Do you think that doctors can ignore product inserts for medications?

MS. WIDLANSKY: Form.

THE WITNESS: It depends on the medication. And it depends on the basis of science for which the doctors are using the medication.

BY MR. SILVA:

Q. Do you have any personal knowledge or any research experience in -- in how product inserts are created for medications?

A. As I said, when I was a resident, one of my professors was on the FDA committee and gave a lecture on the Food and Drug Administration approval of medication process. Her name was Elizabeth Connell, M.D.

Q. How many years ago was that?

A. I was a resident from '83 to '87.

Q. Okay. And this incident occurred in the year 2011?

A. Yes.

Q. So approximately 20 -- 20-some-odd years later?

A. Right.

Q. Do you know what the FDA has done with regards to product inserts in that 20-some-odd-year interim?

A. Well, actually a week ago I had one of my students ask me a question about product inserts. And we opened one up about a birth control pill. And the product insert was dated as being approved something like four years prior to the date that we reviewed the insert. So if it was dated as approved on a certain date, it was certainly standing four years later.

Q. Do you know when the date of approval for the product insert for the Ancef that you ordered the nurses to give on January 26, 2011 was approved?

A. No, because I didn't check the insert on the vial that was administered.

Q. The first thing on this order says admit to inpatient status. What does that mean?

A. That means that if the patient, for example, is coming in for a scheduled C-section that her electronic status in the hospital system is converted to

inpatient status. This would not apply to Ms. McCants because she had already been previously admitted to inpatient status.

Q. Do you know if any work had to be done in registration at St. Mary's to convert Heather McCants from a prenatal patient to a patient that was going to have surgery?

MR. MITTELMARK: Object to the form.

THE WITNESS: I would not know as she was already an inpatient.

BY MR. SILVA:

Q. Do you know if the patient identification has to be changed when she is moved from the prenatal unit to the operating room?

MR. MITTELMARK: Object to the form.

THE WITNESS: No, I do not know that procedure.

BY MR. SILVA:

Q. Do you know how long that procedure takes?

A. I'm not sure that -- that a procedure is involved if the patient is already inpatient admitted as an antepartum that any procedure has to be enacted at all.

Q. When you first saw Heather McCants, she was already in the operating room?

A. No. When I first saw Heather McCants, she was an antepartum patient who I accepted as a transfer.

Q. Okay. I'll be more specific. On January 26, 2011 was the first time that you saw Heather McCants when you entered the operating room?

A. No. I saw Ms. McCants in the preop area before we entered the operating room.

Q. At what time did you first see Heather McCants?

A. I don't recall that I recorded a time.

Q. Was it before or after 3:37 in the afternoon?

MS. WIDLANSKY: Form.

THE WITNESS: It would have to be after.

MR. SILVA: I'll take that one.

THE WITNESS: Okay.

BY MR. SILVA:

Q. The next document I'm going to have you look at is the surgery anesthesia perioperative assessment.

(Plaintiff's Exhibit Number 18 was marked for identification.)

BY MR. SILVA:

Q. Just review it, and then let me know when you're done.

A. Okay.

Q. Is -- First of all, can you identify this

document for me?

A. It's labeled surgery anesthesia perioperative assessment, two pages.

Q. Okay. Is your handwriting anywhere on this document?

A. No.

Q. Do you know who filled this document out?

MS. WIDLANSKY: Form.

THE WITNESS: I recognize the signature of Dr. Lane on January 26, 2011. And then it looks like his handwriting.

BY MR. SILVA:

Q. And can you tell at what time this document was signed at?

A. No. No.

Q. There is an area there that says 1530 right above the signature page --

A. Yes.

Q. -- and the date of 1530. Is that 3:30 in laymen's terms?

A. Yes.

Q. And then there is an area here for assessment, American Society of the Anesthesiologists Class.

Do you ever get involved in assigning patients' ASA ratings?

A. No.
Q. You leave that to the anesthesiologist?
A. Role, yes.
Q. There is an area there, number one, that's circled and then crossed out. Do you know why that's crossed out?
A. No.
Q. Do you know who crossed that out?
A. No.
Q. And then there's an area there circled three and "E". Do you know what "E" stands for?
A. No.
Q. Have you ever had any discussions throughout your career with any anesthesiologists where you gained the knowledge that "E" stands for emergency?
A. No.
Q. And according to the first page of this document, the procedure is C-section, repeat for fetal distress?
A. Correct.
Q. Do you know how Dr. Lane gained the knowledge that Heather McCants' baby was in fetal distress?
A. No.
Q. Did you have any conversations with Dr. Lane where you told him that you were performing a C-section

for fetal distress?

A. I don't have an independent recollection of our conversation.

Q. There is an area here on review of systems on the first page for respiratory. And it's circled negative. Do you see that?

A. Yes.

Q. Okay. Is there anything on that document that states that Heather McCants suffered a respiratory arrest?

A. No.

MR PUYA: Form.

MS. WIDLANSKY: Join.

BY MR. SILVA:

Q. Is there anything on this document that states that Dr. Lane had a discussion with Heather McCants about general anesthesia versus subarachnoid block?

A. Specifically, no. However, it does say on the second page in the bottom quadrant risk/plan/alternatives discussed. Questions answered. Patient/guardian agrees to proceed as planned. And that's I think signed by Dr. Lane.

Q. And do you know what discussions Dr. Lane had with Heather McCants regarding the alternatives to subarachnoid block?

A. No, I do not.
Q. There's an area here on the second page class one, two, three and four of Mallampati class. Do you know what that is?
A. No, I do not.
Q. Is there anything circled there with regards to class one, two, three or four?
A. No.
Q. Is there anything entered in regarding Heather McCants dentition?
It's right below it.
A. Oh, no. I see it now, yes. No.
Q. Or any -- anything entered in regarding Heather McCants' neck range of motion?
A. No.
Q. And with regards to the history of difficult intubation, what is the entry?
A. It's either O-K or -- This is my interpretation of somebody else's handwriting. It's either O-K or O-C with a slash. I don't interpret that -- I'm many not sure how to interpret that.
Q. Okay. Yes is not checked off, is it?
A. No.
Q. Is there anything on this document that states that Heather McCants could not undergo a general

anesthesia?

A. There's nothing one way or the other.

Q. I'll take that.

A. Yes.

Q. Thank you.

The next document I'm going to have you look at is the anesthesia record of January 26, 2011.

(Plaintiff's Exhibit Number 19 was marked for identification.)

BY MR. SILVA:

Q. Is your handwriting anywhere on this document?

A. No.

Q. And according to this document, the anesthesia time is 3:37?

MR PUYA: Form.

THE WITNESS: I'm sorry. The anesthesia time I see in the top left is -- Yes, it starts at 3:37 and then it's at 1636, which is -- I'm sorry. 1618, which is 4:18, yes.

BY MR. SILVA:

Q. There is a box for anesthesia time. It has 3:37 to 4:36. Do you see that?

A. Yes.

Q. And then it has surgery time, and it has 1551 to 1618. Do you see that?

A. Yes.
Q. Is there anything on this document that states that anesthesia was given prior to 3:37?
A. No.
Q. Towards the right column halfway down there's an area here that says antibiotics Ancef two grams start at 1554. Do you see that?
A. Give me one second.
Q. Sure. I'll point it to you.
A. Okay.
Q. It's right there.
A. Yes.
Q. Okay. So according to this document, the Ancef was not given preoperatively, was it?
A. No.
Q. It was given after the procedure at 1554?
A. Correct.
Q. Do you know what pre-induction means?
A. I have a general idea of what it means.
Q. Just as an OB tell me what your understanding is.
A. Before the initiation of anesthesia.
Q. Are you talking about general anesthesia?
A. It doesn't have to be a general only.
Q. It can be any type of anesthesia?

A. Correct. The initiation of anesthesia in doctor talk sometimes can be called the induction of anesthesia, whether it's a spinal or whether it's an IV sedation or whether it's an intubation.

Q. Okay. And I want you to look to the top left-hand corner of this document. There is an area that's checked off that says patient reevaluated pre-induction. Can you tell us what time is entered there?

A. 1538 or 3:38.

Q. Is there any information on this document about the fetal heart rate?

A. Not that I can identify, no.

Q. And then it denotes that the anesthesiologist is Lane and the surgeon is Lopez?

A. Yes.

Q. And it says OB/OR is that B?

A. Yes.

Q. And on the top right-hand corner of this document there is an area there where it says chart reviewed. Is that checked off?

A. Yes.

Q. Thank you.

The next document I'm going to have you look at is -- The anesthesia note I just had you look at is

Exhibit Number 19.

And then the postoperative subarachnoid opioid for cesarean section patients will be Number 20.

(Plaintiff's Exhibit Number 20 was marked for identification.)

BY MR. SILVA:

Q. Can you take a look at that, sir?

Just let me know when you're done.

A. Okay.

Q. Okay. This is a postoperative subarachnoid opioid order for cesarean section patients?

A. Correct.

Q. And does this appear to have been signed by Dr. Lane?

A. Yes.

Q. On January 26, 2011?

A. Yes.

Q. Okay. At 3:30 in the afternoon?

A. Yes.

Q. Did you -- Were you in the presence of Dr. Lane or Heather McCants at 3:30 in the afternoon?

MS. WIDLANSKY: Form.

THE WITNESS: I don't know.

BY MR. SILVA:

Q. This document, if you look at number one, it

states this patient received .3 milligrams of Astramorph, morphine sulfate, and 15 micrograms of Fentanyl by the subarachnoid route on 1/26 at 3:30 in the afternoon.

Is that the anesthesia that was used in this case so that you could perform a C-section?

A. Yes.

Q. Do you know how long it took Heather McCants to be ready to be cut by a surgeon, such as yourself, after she received the subarachnoid block on January 26, 2011?

MR PUYA: Form.

THE WITNESS: No.

BY MR. SILVA:

Q. Do you know if there was any difficulty with administering adequate anesthesia by the subarachnoid block prior to performing the procedure?

A. No, I don't know.

Q. I'll take that. Thank you.

MR. SILVA: Ready for a five minute break?

MS. WIDLANSKY: Okay.

MR. SILVA: Let's go ahead and take a five minute break.

THE VIDEOGRAPHER: Off the video record at 10:59.

(A recess was taken.)

THE VIDEOGRAPHER: We are now back on the video record at 11:09.

(Plaintiff's Exhibit Number 21 was marked for identification.)

BY MR. SILVA:

Q. I'm going to hand you Exhibit Number 21, which is your operative report, sir. Just take a look at the document.

A. Okay.

Q. When you are done, just let me know.

A. Okay.

Q. When did you dictate this operative report?

A. On January the 26th, 2011 at 4:12 in the afternoon.

Q. Okay. And when was this authenticated?

A. February the 1st, 2011 at 12:09 p.m.

Q. Okay. What was the preoperative diagnosis?

A. Intrauterine pregnancy at 27 weeks and five-seventh's days. Prolonged rupture of membranes. Suspected maternal pulmonary embolism after percutaneously inserted control (sic) line catheter was flushed, fetal prolonged deceleration and persistent fetal tachycardia.

Q. And what was the postoperative diagnosis?

A. It was the same.

Q. When -- when you say in the preop diagnosis fetal prolonged deceleration, what does that mean?

A. That means that the fetal heart rate diminished for greater than two minutes and less than ten minutes.

Q. And then you say persistent fetal tachycardia. What does that mean?

A. That means that after the recovery, the baby's heart rate was above 160.

Q. Okay. Was that something that you felt significant, the persistent fetal tachycardia that led you to put it in the preoperative diagnosis?

MR. MITTELMARK: Form.

BY MR. SILVA:

Q. You can answer.

A. There are many reasons why things are included in the preoperative diagnosis. Most of them are because all operations, all C-sections are reviewed at this hospital for appropriateness. So you want to include a sufficient amount of information that would describe the general reasons why the operation was indicated.

It's not intended to be all inclusive or all exclusive of all other causes. But it's -- The documentation should support the reason why you're

removing a 27 week, five-seventh's date baby out of her mother's womb.

Q. In other words, the indication for the procedure?

A. Right. And in this case specifically since the baby was so premature you needed to explain in detail the reasons why the baby needed to be delivered.

Q. Right. And according to this preoperative diagnosis, this cascade of events requiring this baby to be delivered at this time of gestation started with the central line catheter being flushed.

MR PUYA: Form.

MS. WIDLANSKY: Join.

BY MR. SILVA:

Q. Is that your understanding?

A. The cascade?

Q. Yes.

A. Well, yes.

Q. Well, the central line was occluded and needed to be flushed with Cathflo. Heather McCants had a reaction to that, which necessitated a phone call to you, you ordering a C-section, and finally the baby being delivered, correct?

MS. WIDLANSKY: Form.

THE WITNESS: Well, that's one sketch of what

happened. The mother's pulse was also twice normal.

In other words, we say the highway speed limit is 55, twice -- twice that is 110. The mom's fetal -- the mom's, the mother, Ms. McCants' heart rate was documented in that anesthesia record we just reviewed as an exhibit as being double of what is normal. And --

BY MR. SILVA:

Q. And that -- I'm sorry. Go ahead.

A. And that was another reason why the possibility of a maternal pulmonary embolism or suspected maternal pulmonary embolism was a reasonable working diagnosis in a mother who had a respiratory arrest, who had a rapid response and who a had a persistent fetal heart -- I'm sorry a persistent maternal heart rate that was twice the normal speed.

Like I said, if you were a car on the highway, that would be saying like the car was going 110 miles an hour.

Q. Sure. And that -- and that persistent maternal tachycardia or a heart rate, all of that occurred after the PICC line was flushed, right?

A. Yes.

Q. Okay. She didn't have a heart rate that was

elevated prior to the PICC line being flushed, did she?

A. No. Well, not that high, no.

Q. Right.

A. She did have a history of having a slightly elevated heart rate on occasions. But that was at a much lower rate of like 110.

Q. Sure. And you -- You certainly didn't decide that the baby needed to be delivered because the mother had a heart rate of 110, did you?

MS. WIDLANSKY: Form.

THE WITNESS: Yes, I did, but not in the operative report. This was in the progress note that I wrote -- and I think we referred to previously. I'm not sure which exhibit it was.

BY MR. SILVA:

Q. I think you misunderstood my question.

A. Oh, okay. My question is you were testifying that prior to this incident the mother's heart rate at some -- at some times would go into the 110 range prior to this incident. Did you elect to perform a C-section based upon the mother's heart rate going to 110 prior to this incident --

MS. WIDLANSKY: Form.

BY MR. SILVA:

Q. -- at any point in time?

MS. WIDLANSKY: I'm sorry. Form. Mischaracterization of testimony.

BY MR. SILVA:

Q. Go ahead.

A. No.

Q. Okay. When Heather McCants had a heart rate of 110 prior to this incident, did you suspect that she had a pulmonary embolism?

MS. WIDLANSKY: Form.

THE WITNESS: No. Because she had a previous history of maternal tachycardia.

BY MR. SILVA:

Q. Okay. And that was documented on the admission to St. Mary's Medical Center, wasn't it?

A. I believe it was, yes.

Q. So the nurses would or should have known about that?

MR. MITTELMARK: Object to the form.

THE WITNESS: Yes.

BY MR. SILVA:

Q. And you knew about it, right?

A. Yes.

Q. And then the procedure -- What procedure did you dictate in this report?

A. A repeat low transverse cesarean section.

Q. Okay. Then you have a description of the procedure. And part of your description you say the baby had a prolonged ten minute deceleration.

Do you see that about five lines down?

A. Yes.

Q. And then you say it was followed by tachycardia which was persistent. Do you see that?

A. Yes.

Q. Why do you qualify the tachycardia as being persistent as opposed to just tachycardia?

A. That was my interpretation of the strips at the time that the strips were available for me to review.

Q. And when you say persistent, what does that mean?

A. That means that again many times in a labor and delivery unit, certainly in antepartum labor and delivery unit, a mother will roll over flat on her back, and the baby may roll over on the umbilical cord, and you'll have a deceleration. Sometimes the decelerations are less than two minutes. Sometimes the decelerations are more than two minutes.

After a period of intrauterine resuscitative recovery, which doctors generally think is the best way to handle a deceleration, allow the baby to recover

where you have the placenta as the oxygenating unit of exchange as opposed to a premature lung, what will happen is the heart rate will -- the baby's heart rate will go back to a normal range.

Sometimes the baby's heart rate does not go back to a normal heart rate. And that's what appeared to be happening here. In addition to all the things that were happening to the mother where the mother had an acceleration of her heart rate to twice normal that persisted throughout the C-section.

And in combination with a discussion that I had with an internal medicine hospitalist physician that I had spoken to the procedure to proceed with delivery was not only entertained but in actuality performed.

Q. Okay. When did you first speak to that internist?

A. Before the patient arrived on the floor -- I mean on the OR unit.

Q. Okay. Did that internist influence you in any way in delaying the C-section?

A. Delaying?

MS. WIDLANSKY: Form.

BY MR. SILVA:

Q. Yes.

A. No.

Q. Okay. In your description of the procedure, you state here the patient had her PICC line catheter flushed and immediately developed respiratory arrest for which rapid response was called. Do you see that?

A. Yes.

Q. Then you go on to say after an adequate level of spinal anesthesia, she was prepped and draped in the usual sterile fashion.

What did you mean by an adequate level of spinal anesthesia?

A. A level of spinal anesthesia that allowed us to proceed with the surgical procedure.

Q. Okay.

A. An operation where the patient would not perceive an unacceptable amount of discomfort.

Q. Do you know how long it took for Heather McCants to have an adequate level of anesthesia from the time that she was initially given the subarachnoid block?

A. Not in minutes and seconds, no.

Q. Did you examine Heather McCants to confirm that she had an adequate level of anesthesia prior to performing the C-section?

A. Yes. Before I performed the initial incision, I would have done what's called an Allis test where I

take a surgical instrument and pinch the area that I intend to make the abdominal incision on. And usually I pinch a few centimeters north of that area as well to make sure that the patient is adequately anesthetized.

Q. And you did that at 3:50 or sometime thereafter?

A. I don't recall the time, but it was done before the initial incision was made.

Q. Okay. But it had to have been at 3:50 or sometime thereafter, because according to the operative -- perioperative note you were not in the room prior to 3:50; do you agree with that?

MS. WIDLANSKY: Form.

THE WITNESS: Well, again, since I was not the timekeeper, I had other things on my mind, mainly the care and treatment of the mother and the baby. I'd never really tracked the time flow of -- nor did I ever look at my watch or look at a clock to document a specific time that I can recall.

BY MR. SILVA:

Q. Okay. And as you sit here today, do you have any reason to dispute that time that you first entered the operating room at 3:50?

A. Well, you know, clocks in hospitals are interesting things: We have clocks on the wall; we have

clocks on the anesthesia machine; people have wrist watches; people have the computer watch. And they're synchronized to whatever level of degree of synchronization that occurred on that specific date and time.

Since I'm not the timekeeper, and since I can't -- You know, I -- I've seen cases like this where a nurse will be using the time that's on the electronic medical record panel and not the atomic clock that's on the wall. And then I've seen anesthesiologists use the time on the anesthesia machine or the time on their watch or the time on the atomic clock that's on the wall. So there can be minimal time discrepancies with no malintent. I mean everyone is recording a time.

But just like in this room, if we were all to look at our clocks or watches or cell phones or computers, I bet you that they're not all lined up.

Q. Okay. And is it possible then that the baby was born at sometime later than 3:52?

A. As I mentioned before, my interest was in the care and treatment of the mother and the baby. I was not a timekeeper. I will go by whatever the record indicates as the recorded time and not disagree with it, but I was not the authenticator of the time.

Q. Do you know exactly what time this baby was

born at?

MS. WIDLANSKY: Form.

THE WITNESS: No, I do not. Only by -- by what was -- what I was told from other people.

BY MR. SILVA:

Q. What does that mean?

A. Well, like I said, I think one part of the med -- medical record may say that the baby was delivered -- For example, the anesthesia record says 1552. I don't have the nurses note from the operating room. But if I were to find it, it may or may not match up exactly. But sometimes it does; sometimes it doesn't.

Q. Have you seen the nurses note from the operating room?

A. I have in the past. I didn't memorize it. I mean if you want to --

Q. You did -- You did in this case?

A. I have -- I have seen the electronic operative note that I believe Nurse Braga may have authored in terms of times. In fact, it may be one of the exhibits you handed me. And if you'll give me the exhibits, I'll show you which one.

Wasn't one of them the operative -- electronic operative note from Nurse Braga?

Q. It might have been on the prior depo, but I don't think we have it today marked.

A. I'm sorry.

Q. That's okay.

A. I thought I had seen it this morning.

Q. You can look at other records if you'd like.

A. Okay. Let me take a moment.

THE WITNESS: Let's go off the record, and let me find it.

THE VIDEOGRAPHER: Off the record at 11:23.

(A recess was taken.)

THE VIDEOGRAPHER: We're now back on the video record at 11:24. This is the beginning of tape two.

THE WITNESS: I'm referring to the delivery summary, labor and delivery that appeared to be authored by Nurse Braga. And the times between anesthesia and the delivery summary --

Now the anesthesia record, obviously, was recorded by Dr. Lane. And the delivery summary was authored by Josephine Braga, RN. They are coordinate. They match exactly. They say 1552 there was delivery. At 1553 there was the removal of the placenta.

But not in all cases do the -- do the minutes

line up. But not for malintent or not because there is something -- covering something up. It's because people use different time clocks. And the time clocks may or may not be coordinate.

BY MR. SILVA:

Q. Okay. And according to the medical record in this case, the baby was born at 3:52?

A. Both by the delivery summary and by the anesthesia record, correct. But I personally did not record the time of the events.

Q. Okay. So as you sit here today, you can't tell me with any reasonable degree of medical certainty according to your recollection of what time this baby was born?

A. Correct.

Q. Okay.

THE WITNESS: Let her in, 3074. I apologize.

MR. SILVA: If you need to take it. Go ahead. That's okay.

THE WITNESS: That hopefully will have covered it.

BY MR. SILVA:

Q. I want you to continue looking at your operative note here. And it states two-thirds of the way down on the description of the procedure that cord

blood was obtained. Do you see that?

A. Yes.

Q. What was the cord blood obtained for?

A. This cord blood was obtained as a matter of routine so that we can blood type the baby's blood.

A very common problem that occurs in pregnancies is that the mother and the baby do not have the exact blood type. And it cause the baby to turn yellow or jaundice. And there's a blood/blood reaction between the mother's and baby's blood.

So what I did was I opened up the clamp of the umbilical cord and obtained a sample of blood to be submitted to the laboratory for evaluation of the baby's blood type.

Q. Okay. Did you order a cord blood gas?

A. I did not order a cord blood gas because it was not medically indicated.

Q. That was according to your judgment, right?

MS. WIDLANSKY: Form. Asked and answered.

THE WITNESS: Well, no, not only is it to my judgment. But, yes, my judgment indicated that the baby was vigorous with an Apgar of eight at one minute and an Apgar of eight at five minutes. And Dr. Ambroise I believe was the assignor of the Apgar scores as a -- as she was the neonatologist

in attendance at this high-risk delivery.

If doctor -- If there was an issue about the baby's oxygenation or acid base status, Dr. Ambroise had the ability to order a blood gas immediately that would have been much more accurate than an umbilical cord gas.

There is no policy at St. Mary's, nor is there a national policy that indicated that this baby on this case needed to have a cord blad -- cord blood gas obtained.

BY MR. SILVA:

Q. Do you know what the baby's cord blood gas would have been if the baby was born five minutes prior to 3:52?

A. No.

Q. Do you know what the Apgar scores would have been if this baby was born five minutes prior to 3:52?

MS. WIDLANSKY: Form.

THE WITNESS: No.

BY MR. SILVA:

Q. So that would be at 3:47.

Do you know what the Apgars would have been at 3:42, if this baby had been born at 3:42?

A. No.

MS. WIDLANSKY: Form.

BY MR. SILVA:

Q. Do you know what the Apgars would have been at 3:37 if this baby had been born at 3:37?

MS. WIDLANSKY: Form.

THE WITNESS: No.

BY MR. SILVA:

Q. Do you know what the Apgars would have been at 3:32 if the baby had been born at 3:32?

MS. WIDLANSKY: Form.

THE WITNESS: No.

BY MR. SILVA:

Q. Do you know what the Apgars would have been at 3:27 if the baby had been born at that time?

MS. WIDLANSKY: Form.

MR. BLOOM: Join.

THE WITNESS: Respectfully, no.

BY MR. SILVA:

Q. Okay. And same question for cord blood gases if they had been ordered back any of those times, do you know as you sit here today what those cord blood gases would have been?

MS. WIDLANSKY: Form.

THE WITNESS: No.

MR. BLOOM: Join.

THE WITNESS: Okay. Let me go off the

record --

MR. SILVA: Go ahead.

THE WITNESS: -- for one tiny second.

THE VIDEOGRAPHER: Off the record 11:28.

(A recess was taken.)

THE VIDEOGRAPHER: Back on the record at 11:29.

BY MR. SILVA:

Q. Let's see. We are up to -- That's 21?

A. Yes, sir.

Q. Thank you.

MR. SILVA: I'm going to mark this document as Plaintiff's Exhibit Number 22.

(Plaintiff's Exhibit Number 22 was marked for identification.)

BY MR. SILVA:

Q. This is Dr. Jumapao's consultation note. Is this the doctor that you spoke with --

A. Yes.

Q. -- regarding Heather McCants' condition?

A. Yes, sir.

Q. Okay. And according to this document, there's a history there. And can you read that history into the record?

A. This 24-year-old white female with a known

history of sinus tachycardia as well as history of preeclampsia from the second pregnancy. Patient apparently was transferred from Indian River Hospital last January the 12th for a premature rupture of membranes. She has been here for a quite a while, and today she was noted to have a flattened PICC line and was given Cathflo, which patient immediately was complaining of shortness of breath, getting cyanotic, hypoxemic, desaturated and immediately had an emergent C-section. Apparently, the fetal heart rate also desaturated.

Q. Okay. Do you know where Dr. Jumapao got this information?

A. No.

Q. Do you know if Dr. Jumapao ever examined Heather McCants prior to the C-section?

A. I don't believe she did.

Q. Okay. And according to this consult note, what time was it dictated at?

A. 1659.

Q. That's 4:59?

A. Yes.

Q. Did you -- did you talk to Dr. Jumapao in the postop recovery area?

A. I did. But I also spoke to her before

Heather McCants arrived.

Q. Okay. And that conversation that you had with Dr. Jumapao prior to the surgery, did either you or Dr. Jumapao conclude that you needed to perform any additional tests to investigate this possible pulmonary embolism that delayed the delivery of the baby?

A. Well, I don't know that anything delayed the delivery of the baby. So could you rephrase your question.

Q. No, I'm not going to rephrase. I'm going to --

A. Okay. Could you repeat the question again?

Q. Yeah. I'm going to ask her to repeat it back to you so you can answer it.

A. Okay.

(The question was read by the reporter.)

MR. MITTELMARK: Form.

MS. WIDLANSKY: Form.

MR PUYA: Join.

THE WITNESS: I don't understand your question, because no testing was performed. And there was no delay in performing the cesarean section.

BY MR. SILVA:

Q. Okay.

A. So if you could -- If you choose to rephrase it, it's up to you. Otherwise I'm just going to simply say that factually there was no delay in delivery of this baby. And there -- there was no discussion of a test that could have in theory or an evaluation needed to have been performed in theory that would have caused a delay.

Q. Okay. So I want to be clear about this. You didn't discuss any tests with Dr. Jumapao that needed to be performed or were performed prior to the C-section, correct?

MR PUYA: Form.

MS. WIDLANSKY: Form.

MR. BLOOM: Join.

THE WITNESS: To the best of my recollection that's correct.

BY MR. SILVA:

Q. Okay. Did -- did -- Was there a spiral CT performed prior to the procedure?

A. No.

Q. Was there a VQ scan performed prior to the procedure?

A. No.

Q. Was there any blood work such as a D-dimer performed prior to the procedure?

A. No.

Q. So the entire pulmonary embolism workup was performed after this procedure, correct?

A. Yes.

Q. I'm going to have you take a look at what we marked earlier as Plaintiff's Exhibit Number 14, which is the timestamp for you coming into the hospital.

Prior to you arriving on the L&D floor at 3:33, was Heather Mc -- was Heather McCants in the preop holding area when you arrived there at 3:33?

A. No.

Q. And is that the reason that you left the OB operative area to determine where she was?

A. Yes. And where they were in the process of getting her ready for a C-section.

Q. Did you call back to the antenatal unit, or did you just decide that you were going to walk up there and see what -- what the delay was?

A. Both.

Q. So did you call first?

A. Yes.

Q. And you spoke -- Who did you speak with?

A. I don't know that I independently recall with exactitude who I spoke to. I may have spoken to one person who received the phone call and then may have

transferred the phone call to another person. That's what I recall.

Q. Did you make the phone call before you left the OB operative area to go back -- back up to the floor?

A. Yes.

Q. Okay. And after you made the phone call, why did you decide to go back to the -- to the prenatal area?

A. Because when the elevator door opened, Laurie, the director of labor and delivery unit, walked out and said she was being -- Ms. McCants was being transported and was on her way.

Q. Right. But my question is after you got off the phone with the antenatal unit, you still decided to leave the OB operative area and go back to the elevator bank, and you were going up to Heather McCants' floor. Why did you do that?

A. In the event that there was something I could do to facilitate the movement of Ms. McCants. I knew Ms. McCants. Ms. McCants is a wonderful person. She does have some medical situations that are unique to her. She was 350 pounds. A 350-pound patient sometimes have to be rollered or may have to be facilitated in their movement, and I'm obviously a large person. And

the nurses -- I know Nurse Duckworth is not that big. Okay?

And depending on if there was a -- if there were reasons that I could facilitate the transfer of Ms. McCants more timely, my intent was to go on the floor and facilitate.

Now, there is also the possibility that since I didn't know moment by moment exactly where they were in the process, if there was something that I could do to facilitate her movement towards the OB/OR, I thought that by physically going up there and seeing personally what's going on that it would resolve my own anxiety and may facilitate the transfer as I said.

Q. Would you expect Janis Duckworth, her attending nurse, to ask for help if she had any trouble transporting her to the operating room?

A. Yes.

Q. Do you know how many other nurses and available staff were around Heather McCants when it was decided that she needed to be transported to the operating room?

A. I didn't know exactly. But as I said, when the elevator doors opened and I was in front of the elevator bank and Laurie came out, I was told that they had adequate help and she was on her way.

Q. Okay. And when -- when was the first time that you set eyes on Heather McCants?

A. When she rolled into the area outside the operating rooms on the OB floor, on the first floor.

Q. Okay. So after you spoke with Laurie Matich, you went back to the operating room area. And that's when you entered that area again at 3:37?

A. Yes.

Q. Okay. And how long were you there waiting for Heather McCants before you first laid eyes on her?

A. I don't know. Again, I never -- I never became a timekeeper. I was more concerned to ensure the safety of Ms. McCants and her baby.

Q. Well, when you went back at 3:37, she was not in the OB operating area, right?

A. That's correct.

Q. Okay. So at some point in time after the time that you entered the OB operating area the second time, which was 3:37 and four seconds p.m., at some point in time thereafter Heather McCants arrived to the OB operating room area, right?

A. Yes.

Q. And then still at that time she had to be evaluated by anesthesia?

A. Correct.

Q. And she had to have her anesthetic given, whether it was general anesthesia or subarachnoid block or an epidural?

A. Correct.

Q. She had to obtain adequate anesthesia before you could perform the procedure, right?

A. Correct.

Q. And do you know what your involvement was from 3:37 until 3:50 in regards to making Heather McCants' C-section occur as quickly as possible?

A. Yes. What I did was I contacted the hospitalist Dr. - I don't know if I'm massacring this name --

Q. Jumapoa?

A. -- Jumapoa. And I had moved some carts that were in the way prior to Ms. McCants' arrival to the operating room area, the preop operating room area.

So in other words, I tried to clear a clear path so that when she arrived she could be moved into the room as timely as reasonably possible.

Q. Okay. When you went back into the OB operative area at approximately 3:37, was there an operating room staff assembled to perform this C-section?

A. I believe that there was an operating room

staff available, yes.

Q. Had they -- Were they performing another procedure?

A. When I initially presented to the OB preop area and poked my head into an operating room where they were concluding another cesarean section, but it seems to me that at St. Mary's there are resources for more than one C-section in terms of nursing staff, in terms of anesthesiologists that are available.

Q. From the time that you first got to the labor and delivery area at 3:33, do you know if any of the nurses requested that Dr. Sanches start the C-section prior to your arrival?

MR. BLOOM: Form.

MS. WIDLANSKY: Form.

THE WITNESS: I have no knowledge of anything that happened before my arrival.

BY MR. SILVA:

Q. Okay. So you have no knowledge prior to 3:33 of what occurred in the antenatal unit with regards to preparing Heather McCants to be brought down to the operating room, right?

A. Other than what I was told by I believe it was Nurse Duckworth, correct.

Q. And you have no knowledge of what time the

Rapid Response Team was called?

A. At that time, no. Subsequently when I saw the medical records in preparation for this series of depositions and probably when -- immediately after when the chart became available to me in the preop area, yes.

Q. Prior to 3:33, did you instruct Lisa Sanches, M.D., to start the C-section?

A. I did not speak with Lisa Sanches. And, therefore, I did not instruct or not instruct Lisa Sanches, Dr. Lisa Sanches as to what she should do.

Q. Did prior to 3:33 Lisa Sanches, M.D., the OB, 24-hour OB that day, did she contact you and volunteer to start the C-section prior to your arrival?

A. I believe I've already mentioned that Dr. Sanches and I had no communications before or subsequent in regards to the McCants' case.

Q. Do you have a private practice office on the campus of St. Mary's Medical Center?

MR. MITTELMARK: Object to the form.

THE WITNESS: No.

BY MR. SILVA:

Q. Okay. Do you know if the 24-hour OB group has a private practice office on the campus of St. Mary's Medical Center?

MR. MITTELMARK: Object to the form.

THE WITNESS: They have one on the campus, yes.

BY MR. SILVA:

Q. They do, right?

A. Yes.

Q. And what -- what is your understanding of where that building is in relation to the hospital?

MR. MITTELMARK: Object to the form.

THE WITNESS: It's -- You have to cross the west parking lot, west doctors' parking lot to enter the actual physical property of the hospital.

BY MR. SILVA:

Q. Okay. And does the front area of the hospital get closed off at a certain time at night? There is like a guard gate there.

A. Yes. They -- they -- they have gates in the perimeter that are generally closed either at -- after 11:30 or somewhere around midnight.

Q. Okay.

A. And access is restricted to the eastern entrance.

Q. That's the Greenwood entrance?

A. Yes. The Greenwood Avenue entrance, yes, sir.

Q. Okay. And if the guard gate is closed at night, the only way to access the physicians' office for

OB -- OB/GYN Specialists is also there through the Greenwood area?

A. Correct.

MR. BLOOM: Form.

BY MR. SILVA:

Q. Okay. There is no other way to access that office space after 11:00 or 12:00 at night, correct?

A. Correct.

Q. Because this property is -- I think it's fenced or gated?

A. It's -- it's fenced. They have an ironworks fence that runs the perimeter of the property.

Q. Do you know if Dr. Lane ever called Dr. Sanches and requested that she start the C-section prior to your arrival?

A. I have no knowledge of what Dr. Lane did.

Q. Do you know if the nurses went up the chain of command to try to get an OB to perform the C-section prior to your arrival at 3:33?

MR. MITTELMARK: Object to the form.

THE WITNESS: I don't know.

BY MR. SILVA:

Q. When you order -- When a physician orders a C-section or any surgical procedure, an OB/GYN at St. Mary's Medical Center, do you know if it's a

requirement for the nurses to enter that physician's order into the chart?

A. I don't know procedurally whether that's the case or not.

Q. Do you know if the nurses wrote a telephone order for a C-section -- for the C-section that you ordered?

A. I don't know. I could look at the records with -- with that in mind.

Q. Did you ever see any telephone order for a C-section by the nurses in this case?

A. Not to my recollection, no.

Q. When you normally call in an order by telephone where the nurse writes down your instructions under the physician's orders, do you expect the nurse to time and date that order?

MR. MITTELMARK: Object to the form.

THE WITNESS: Well, in general, yes. But there are some circumstances where I think care of the patient takes precedence over documentation.

And documentation -- You know, sometimes things happen very acutely in obstetrics. And I think reasonable people would not want the nurses to stop caring for the people that they are caring for and write extensive, sophisticated notes, but

would prefer that the medical needs of the patient be addressed first and then documentation can occur at a later time.

BY MR. SILVA:

Q. You're talking about emergency situations, right?

MS. WIDLANSKY: Form.

THE WITNESS: We're talking about --

MR PUYA: Join.

THE WITNESS: There's a -- there's a range of events. If we're talking about an event that's evolving that requires the full attention of the nurse to stabilize or preserve life and care for a patient, I would not want that nurse to be documenting. I would want that nurse to do those things that a nurse should do by her actions, and then the documentation can come later on.

BY MR. SILVA:

Q. Do you know how many nurses were available to write a physician's telephone order at the time that you ordered the C-section?

MR. MITTELMARK: Object to the form.

THE WITNESS: I don't know the number of nurses that were available. But if you -- It always seems that, again, if we're talking about an

emergency, I think all the nurses respond to being available to do those things they need to do or want to do or can do to make the situation as good as it can be in an emergency situation.

We understand documentation is important. But documentation is not number one when patients' lives are at stake or there may be a concern that a patient may deteriorate to an emergency situation that can get out of hand.

BY MR. SILVA:

Q. The most important thing, you would agree, is to take care of the patient as quickly as possible to avert a bad outcome for the patient or the baby, right?

A. Yes.

Q. Did you ever conclude that Heather McCants had an allergy to Cathflo?

A. No. I did not make a -- I did not make the determination of her relationship with Cathflo.

Q. Okay. I'm going to hand you what I'm marking as Plaintiff's Exhibit Number 3 (sic), which is a physician's order timed at 7:35 and dated 1/26.

(Plaintiff's Exhibit Number 23 was marked for identification.)

BY MR. SILVA:

Q. Is that your handwriting?

A. No, it is not.

Q. Do you know if that's Dr. Jumapao's handwriting?

A. I don't know that -- what her handwriting looks like. But I can see that at -- It seems like the first letter is a J, and it ends with P-O-A.

Q. Okay. Okay.

A. But I also see there is a slash and another signature. So I cannot speak to the author of the notation that you're referring to as allergy to Cathflo.

But her name is it looks to me like -- I would have to say as a doctor reading doctors' handwritings that Jumapoa slash P-A-P-H and then scribble.

Q. Okay. And what is entered into that physician's order?

A. Allergy to Cathflo.

Q. Do you know how Dr. Jumapao concluded that Heather McCants had an allergy to Cathflo?

MR. MITTELMARK: Object to the form.

MS. WIDLANSKY: Form.

MR. BLOOM: Join.

THE WITNESS: Well, I'm not sure that that determination was made conclusively.

I think, you know, from my interpretation of Dr. Jumapoa's notes in an abundance of precaution

she wanted to restrict the contact of Cathflo and Mrs. McCants.

And allergy -- You know an allergy to me means something perhaps very specific, and to other people it may not be as specific. An allergic reaction to me is a histamine mediated response, which I don't believe was the case in the descriptor of what happened when Ms. McCants had her PICC line flushed with Cathflo.

BY MR. SILVA:

Q. Did you disagree with that statement: Allergy to Cathflo?

A. Again --

MR. MITTELMARK: Object to the form.

MS. WIDLANSKY: Join.

THE WITNESS: Again, in doctor talk as I was trained, allergy means one thing. There are many substances that people come in contact with that have disagreeable reactions to.

For example, some patients say that, well, you know, I'm allergic to Percocet; it makes me nauseous.

Well, that -- that's really a side effect and not a true allergy.

There are other patients who say, I'm allergic

to Percocet, but since I'm having surgery, that's what I want, and I'll deal with the side effect.

I think in an abundance of caution, my interpretation what Dr. Jumapao's name appears on this order is in an abundance of precaution to alert all the members of the health care team that this order be entered so that Ms. McCants and Cathflo did not become friendly again.

BY MR. SILVA:

Q. Did you ever have any discussions with Dr. Jumapao about that entry: Allergy to Cathflo?

A. No.

Q. And at the top of this form it says allergy, and it has Cathflo next to it?

A. Yes.

Q. Do you know if any policy or procedure exists at this hospital, St. Lucie -- or St. Mary's Medical Center for the maintenance of PICC lines?

A. I have seen a policy and procedure for maintenance in the past, yes.

Q. When you left this facility at 4:15, do you recall where you went?

MS. WIDLANSKY: Form.

THE WITNESS: No.

MR. SILVA: Okay. All right. Thank you for

your time.

THE WITNESS: Yes, sir.

MR. MITTELMARK: I'm going to have questions.

MR PUYA: Go ahead.

MR. MITTELMARK: Okay. Dr. Lopez -- Dr. Lopez, do you need a break, because I'm going to have some questions for you?

THE WITNESS: No, I'm -- I'm fine.

MR. MITTELMARK: Great.

CROSS-EXAMINATION

BY MR. MITTELMARK:

Q. Dr. Lopez, I introduced myself to you before. I'm Mike Mittelmark. I represent St. Mary's Medical Center. I know you covered a lot of ground about January 26, 2011, but I want to take you back to when Ms. McCants was -- or Mrs. Shelton now, but Ms. McCants at the time, was admitted to St. Mary's Medical Center.

And what I would like to do is I know you covered this in your first deposition, but just tell me in 2011, January 2011, who was your employer?

A. I was employed by Berto Lopez, M.D., P.A.

Q. Were there any other employees of that professional association in January of 2011?

A. Yes. I had between 11 and 13 employees in addition to myself.

Q. And what physicians were employed with Berto Lopez, M.D., P.A., in January of 2011?
A. I was the only physician employed.
Q. Okay. So in January of 2011 who paid your salary?
A. Berto Lopez, M.D., P.A.
Q. Who controlled your vacation schedule?
A. Berto Lopez, M.D., P.A.
Q. Who controlled your on-call schedule?
A. Berto Lopez, M.D., P.A.
Q. Who paid taxes for you?
A. I'm not -- Probably Berto Lopez M.D., P.A., paid part of the taxes.
Q. I gotcha. I gotcha. Did you get a W-2 form from Berto Lopez, M.D., P.A.?
A. I believe I did, yes.
Q. And health insurance, who paid for that?
A. Berto Lopez, M.D., P.A.
Q. Okay. So do you recall back in January of 2011 how it was that you first became involved with Heather McCants as a patient?
A. Yes. The perinatologist, Dr. Stoessel, contacted me and asked if I would be willing to take a high-risk obstetrical patient as a transfer patient from Indian River Medical Center who had ruptured her

membranes prematurely.

Q. And tell us a little bit about Dr. Stoessel. Who is that?

A. Dr. Stoessel is a perinatologist. That means on OB/GYN who specializes in high-risk pregnancies. And he was involved in a perinatal transfer unit that was independent of St. Mary's hospital. And for a long time we accepted perinatal transfers from about a ten county service area.

Q. All right. You take all comers, don't you?

A. We take all comers. And for -- for hospitals that do not have that level of care available for their high-risk patients. In other words, St. Mary's has a Level 3 nursery, has a pediatric hospital, has many pediatric subspecialists, a pediatric open heart surgeon, which is unique in Florida. One -- You know, one of the few centers that has all of these services available.

And for a number of years, in fact, from the beginning of my career at St. Mary's, I've been involved in one way or another with accepting patients independent of the hospital that they were coming from or independent of all other characteristics, but because of their high-risk nature to bring them to a facility that could provide the appropriate care for the patient

and their unborn babies.

Q. And in this case that facility was St. Mary's Medical Center?

A. Correct.

Q. And you would agree that prior to Ms. McCants being admitted to St. Mary's Medical Center I believe on January 12, 2011, you had never met her before?

A. Correct.

Q. So what I have in front of me, and if your counsel has a copy, otherwise I'll provide you my copy, is an OB history, physical and admit note. And I'd like you to take a look at that.

MR. MITTELMARK: And we're going to go ahead and mark that as the next exhibit.

MR. SILVA: You mean Defense -- Defense 1?

MR. MITTELMARK: Okay. Defense 1. That's fine.

(Defendant's Exhibit Number 1 was marked for identification.)

BY MR. MITTELMARK:

Q. Dr. Lopez, what is that document that you're looking at?

A. That is an obstetrical history, physical and admit note that was completed by me on January 12th of 2011.

Q. And can you just briefly describe what it is that you did and how it was that you came to write on such a document?

A. As part of the medical record obligation, this is an instrument that details why Ms. McCants was hospitalized and needed the services of hospitalization, and specifically indicated her past history of having prenatal care by Dr. Zoffer and having had premature rupture of membranes, two previous cesarean sections and having abnormal prenatal labs, which included a positive alpha-fetoprotein test which made this a very high-risk pregnancy at 25 weeks of gestation.

Q. And that's your signature, right?

A. Yes.

Q. And you dated it, correct?

A. Yes.

Q. And you obtained this information from speaking to Ms. McCants?

A. Correct.

Q. So as of January 12, 2011, you were aware of Ms. McCants and her prenatal history and the reason for her admission, right?

A. Yes.

Q. Okay. So the next thing I have is a consultation report dated January 13, 2011.

MR. MITTELMARK: We'll go ahead and mark that as a Defense Exhibit Number 2.

(Defendant's Exhibit Number 2 was marked for identification.)

BY MR. MITTELMARK:

Q. And I just need you to identify what that document is.

A. This is a document dictated by Dr. Ruel Stoessel, the high-risk perinatologist, as a consultation that was performed on January the 13th, 2011 on Ms. McCants.

Q. And what history did Dr. Stoessel dictate based on his -- your review of his consultation?

A. This is a patient who was transferred from Indian River Memorial Hospital because she had preterm, premature rupture of membranes, which occurred on January the 12th at 10:30 in the morning.

He details the high-risk factors that included the preterm rupture of membranes. She also -- He also details that she had failed her glucose screen at 145, but had passed her three hour glucose test. She was known to have an elevated white count at Indian River Medical Center of 30,000, which is abnormal, and a positive shift to left, which was potentially suspicious for infection.

Furthermore, this patient was approximately 26 weeks pregnant and had an estimated fetal weight of one pound, fourteen ounces. The amniotic fluid index was 7.5, which was -- appeared to be clinically stable, meaning it wasn't going up or down.

There were no overt signs of infection. But in abundance of precaution, antibiotics were prescribed. And the patient was to be monitored for temperature, white count, evidence of a foul discharge, contractions, fetal heart rate that's high and mother's heart rate that is high. And that she needed periodic high-risk monitoring. And that she needed to have a C-section since she's had a prior C-section.

But the goal was to give her baby a chance to grow as large as possible and to monitor the mother to make sure she was safe and within normal parameters.

Q. Okay. You would agree that that was your goal as well, right?

A. Yes.

Q. And you and Dr. Stoessel were taking care of Heather McCants as of January 12, 2011?

A. Correct.

Q. And Dr. Stoessel dictated in his consultation note that he discussed the risk of infection with Ms. McCants.

As a board certified OB/GYN physician, can you tell us what the risk of infection would be for a patient such as Heather McCants?

MR. SILVA: Object to the form.

THE WITNESS: As to the mother, the risk of infection would include the uterus could be infected because one of the barriers that normally is present was absent with the rupture of the membranes.

Additionally, the baby was at risk of an infection. And this is -- this is a problem because if a baby gets an infection, it could harm the brain, it could harm the heart and the lungs and the kidneys. They could place the baby's life in jeopardy. Infection is a very serious thing. Especially in a baby this small, one pound and fourteen ounces by estimation.

BY MR. MITTELMARK:

Q. So this is what you would consider as a board certified OB/GYN physician as a high-risk patient?

MR. SILVA: Object to the form.

THE WITNESS: Oh, yes. This patient is high risk for many reasons. The water broke when the mother was less than 27 weeks. The baby was at risk of infection and prematurity and premature

delivery.

Now, prematurity when you're talking about a one pound, fourteen ounce baby, you're talking about a baby whose brain isn't developed yet. The blood vessels, the arteries and the veins aren't ready to come out. The digestive tract isn't ready to come out. The lungs aren't ready to come out. Come out -- What I mean by come out, I mean come out into the world where we as adults and as -- as full-term babies have come out with our brains, our lungs, our digestive tracts ready to go.

And babies' brains generally don't deliver till -- I mean don't fully mature until six months after a full-term baby is delivered, let alone a baby that's 13 weeks premature.

So this baby was at a tremendous risk of not being whole, not having all the things that a full-term baby would have.

Furthermore, during the testing of Ms. McCants' pregnancy, we found out that she had a couple of abnormalities. She had a positive alpha-fetoprotein test, which is a protein test that indicates that something bad might happen to this baby or maybe this baby is not quite right.

And she had had to have a special test called

level 2 ultrasound, which is a very detailed ultrasound to -- to look for any sort of abnormalities.

She failed her sugar screen, but passed her -- her three hour glucose test.

Now, this baby is very different than the two other children she had. She had one child that was eight pounds, six ounces. And she had another baby that was seven pounds. Both of them delivered by C-sections where she had other problems that made her high risk.

So she was in the scope of high-risk patients in the highest level of high risk that high risk consists.

BY MR. MITTELMARK:

Q. And you as a board certified OB/GYN physician have been caring for these types of patients with these types of high-risk conditions your entire career, true?

A. Correct. With the benefit of a perinatologist like Dr. Stoessel and a hospital and a team of nurses and doctors that can help and support the babies once they are born, yes.

Q. Okay. What I'm going to show you next is your progress note for January 13, 2011. I just need you to take a look at it, verify that it is your progress note.

And I'd like you to read it into the record.

MR. MITTELMARK: And if I didn't say it, mark as the next Defendant's exhibit. I think we are at Three.

(Defendant's Exhibit Number 3 was marked for identification.)

THE WITNESS: The note is dated January 13, 2011. No contractions. Afebrile. Vital signs stable. The fetal heart rate was recorded as 145. The estimated fetal weight was one pound, fourteen ounces. And the baby was head down, vertex. The amniotic fluid index was 7.5.

My assessment was intrauterine pregnancy at 25 weeks. Preterm rupture of membranes. Positive AFP, which is alpha-fetoprotein test. Previous cesarean section times two. Continue with the steroid series, and I ordered and obtained a NICU consult.

BY MR. MITTELMARK:

Q. Okay. And why did you order the NICU consult?

A. Because -- Several reasons. First of all, the NICU at St. Mary's is a special NICU. It's a Level 3 NICU. It takes care of the earliest of the earliest. And these are babies that many times they're quite sick.

Again, Ms. McCants had two previous full-term

babies. She had no previous premature babies.

So part of the reason I ordered the consult was for her education of the risk of the baby she was presently carrying.

The NICU consult usually entailed a neonatologist, which is a pediatrician with special training of dealing with high-risk babies coming to the bedside and assessing the patient in a timely way, explaining to the patient the things that might be expected if certain things might happen.

For example, if the baby were born premature, the brain, the lungs, and the digestive tract are nowhere near ready. If the membranes have been ruptured for a long time, this baby may need to be put on antibiotics for a while. This baby may have to have help breathing and may have to have a tube put down its throat.

They basically go over all the things that might happen for a baby that's going to be potentially born prematurely. And the goal of that is both to prepare the patients mentally and to educate them as to what may happen, and -- and to try to decrease the risk of surprise and also to be -- initiate that engagement of the patient in the care of their -- of their babe before it comes out.

Q. Okay. So now let me stop you. You're admitting this patient on January 12th. You get Dr. Stoessel involved as a perinatologist on January 13th. And you're also seeing Heather McCants as a patient because you're drafting a progress note on January 13th, correct?

A. Yes.

Q. And then you ask for a NICU consult. So you want another specialist to get involved in the care and treatment of Ms. McCants and her unborn fetus?

A. Correct.

Q. And I want to show you a prenatal consult note. And it's I believe signed by Jade Sha, S-H-A, M.D. I'm going to ask you to take a look at that and tell me do you know who Dr. Sha is?

A. Yes. Dr. Sha is one of the neonatologist, the pediatricians with special high-risk training, that work at St. Mary's hospital.

MR. MITTELMARK: And we'll go ahead and mark that as the next Defendant's exhibit.

(Defendant's Exhibit Number 4 was marked for identification.)

BY MR. MITTELMARK:

Q. So now we have you, the board certified OB/GYN, we have the perinatologist, and we have the

neonatologist all involved in the care and treatment of Heather McCants as of January 14, 2011?

A. Yes.

Q. And I have another progress note from you that's dated January 14, 2011. I will just ask that you read that into the record.

MR. MITTELMARK: And we're going to mark that as Defendant's Exhibit Number Five.

(Defendant's Exhibit Number 5 was marked for identification.)

THE WITNESS: On January 14th --

MR. MITTELMARK: Or Six. I'm sorry. I'm losing track.

THE WITNESS: -- 2011 she denies contractions. Her amniotic fluid index is 7.5 today with a biophysical profile that is 8 out of 8. She was positive beta strep by the cultures that we did when she was admitted. She did not -- She was afebrile. Her vital signs were stable. Her abdomen was soft, non-tender and there was fetal heart activity.

She was assessed as a intrauterine pregnancy at 26 weeks, 1 day with preterm rupture of membranes, positive beta strep.

My plan was for her to continue IV

antibiotics. And the NICU consult I saw had been completed. And then I signed it.

BY MR. MITTELMARK:

Q. Okay. I have another progress note that's dated January 14, 2011. And I think it says MFM at the top. Would you know what that stands for?

A. Maternal fetal medicine.

Q. Right. And it's authenticated by Aaron Deutsch. Do you know who that is?

A. Yes. He is also a high-risk perinatologist, a OB/GYN who has special training in high-risk pregnancies, who was part of the Dr. Stoessel group.

Q. I have another progress note which I think was signed by you on January 18, 2011. I'd just like you to review it and read it into the record, please.

A. The note is dated January looks like 8th, 2011. No vaginal leaking. Afebrile. Vital signs stable. Fetal heart rate 145. Positive accelerations. Biophysical profile, 8 out 8. AFI, 11.5. White blood count, 13,000. Hematocrit, 31.

My assessment: Intrauterine pregnancy at 26 weeks, 4 days. Preterm rupture of membranes. Monitor for chorio.

MR. MITTELMARK: Okay. Mark that as the next Defendant's exhibit.

(Defendant's Exhibit Numbers 6 and 7 were marked for identification.)

BY MR. MITTELMARK:

Q. I have another progress note which looks like it was signed by you dated January 19, 2011. Again, I would like you to look at it and read it into the record, please.

A. January 19, 2011. No contractions. No leaking. She was afebrile. Her vital signs were stable. Her blood -- Her biophysical profile was 8 out of 8. And her amniotic fluid index was 11. Her abdomen was soft, non-tender. Her fundus was soft. The fetal heart rate was 145. There were no contractions.

She was assessed as an intrauterine pregnancy at 26 weeks, 6 days. Preterm rupture of membranes. My plan was to monitor for fever or chorioamnionitis.

Q. So now, Dr. Lopez, I need you to assume that you have not seen Heather McCants from January 19, 2011 until the date of delivery. How would you describe Heather McCants as of January 19, 2011 as a patient that had been admitted to St. Mary's for one week?

MR. SILVA: Object to the form.

MS. WIDLANSKY: Join.

THE WITNESS: She is a high-risk obstetrical patient on the basis of her pregnancy in terms of

she had prematurely broken her bag of water, she had a premature baby that had been seen by multiple consultants.

I mean her list of high-risk factors include those that belonged to her, which would include she had a history of a previous rapid heart rate, she had a history of two previous C-sections. She has -- She was known to be approximately 350 pounds. She had failed her glucose screen, but passed her three hour test.

She had demonstrated a positive AFP test, which is an indicator of a bad potential baby outcome.

She had been counseled by two perinatologists, at least two OB/GYNs, myself and Dr. Tum, the high-risk neonatal pediatrician about that she was carrying a high-risk baby that had risk factors for premature delivery, infection that could affect multiple organ sites in the baby, the possibility of other troubles related to her baby that dealt with what -- you know, having to have a number of lines put in, like IV lines, umbilical artery catheters, having to have a lot of evaluations of the baby's brain to see if there were hemorrhages or if there was damage to the brain because of her

preexisting prematurity and preexisting preterm rupture of membranes.

She was high risk of the high risk.

BY MR. MITTELMARK:

Q. Okay. So now I need you to assume that on January 22, 2011 Ms. McCants was seen by a maternal fetal medicine specialist and an OB physician.

On January 23rd Ms. McCants was seen by the maternal fetal medicine specialist and an OB physician.

On January 24, 2011 Ms. McCants was seen by a maternal fetal medicine specialist and an OB physician.

And on January 25th Ms. McCants was seen by a maternal medicine physician at 8:15 p.m. and an OB physician at 9:00 p.m.

Would you agree that Heather McCants was never abandoned by any physician while she was a patient at St. Mary's Medical Center?

MR. SILVA: Object to the form.

THE WITNESS: Yes.

BY MR. MITTELMARK:

Q. And that's the kind of attention that you would expect a patient like Heather McCants to receive, that is being seen by a maternal medicine specialist and an OB physician every day while she was a patient at St. Mary's?

A. Yes.

MR. SILVA: Object to the form.

BY MR. MITTELMARK:

Q. Now, Ms. McCants -- I'm sorry. Dr. Silva showed you a nurses note which said that Dr. Tum was rounding on Heather McCants at approximately 1:00 on the afternoon of January 26, 2011. Do you recall that from the nurses note?

A. Yes.

Q. What does that mean? Well, first of all, who was Dr. Tum? And I know you describe -- Is it a him?

A. Yes, it is a him.

Q. Describe again Dr. Tum. Who was that?

A. Dr. Tum is an obstetrician who I cross-cover with who has practiced at St. Mary's in excess of 30 years and was intimately involved with management of the high-risk obstetrical patients from -- again, from transferring in from other facilities.

He has an independent medical practice. He's an M.D. And we share office space, and we share office staff. But we have separate corporations.

Q. So based on your custom, habit, routine cross-covering with Dr. Tum, what would you have expected him to have done if he rounded on a patient such as Heather McCants?

A. To have eval --

MR. SILVA: Object to the form. Go ahead.

THE WITNESS: To have evaluated her by taking an interval history of what had happened since the last time she was seen by an obstetrician. To evaluate her by a physical examination to see if her uterus was tender. To look at the objective information, for example, the temperature chart, the vital signs, the blood pressure, the pulse, to look at the fetal heart rate, to look at whether or not any of the fetal testing, the biophysical profiles, if the CBC was indicating evidence of an infection in the baby or in the mother.

And then assess the patient, which is summarize some of the factors, the high-risk factors. And then have a plan of care for intervention or nonintervention depending on what was indicated.

BY MR. MITTELMARK:

Q. Okay. I know it's two-and-a-half years ago, but do you recall any conversations with Dr. Tum about Heather McCants as a patient after he rounded on her at approximately one p.m. in the afternoon?

A. No.

Q. And based on your experience, custom, habit

with Dr. Tum cross-covering for you, would you have expected a phone call or some type of communication with him had there been a problem with Heather McCants that required immediate attention?

A. Absolutely.

MR. SILVA: Object to the form.

BY MR. MITTELMARK:

Q. Now --

MR. SILVA: You're talking about to -- prior to the Cathflo injection?

MR. MITTELMARK: Prior to -- Between the time that Dr. Tum rounded, any dates, any conversations that he had with Dr. Tum. Because I know Dr. Tum was at the delivery.

BY MR. MITTELMARK:

Q. So you would agree then, Dr. Lopez --

MR. MITTELMARK: If you need to take that -- I'm sorry.

THE WITNESS: Sorry. Can we go off the record for just one second, please?

MR. MITTELMARK: Yes.

THE WITNESS: I apologize.

THE VIDEOGRAPHER: Off the record at 12:20.

(A recess was taken.)

THE VIDEOGRAPHER: We're now back on video

record at 12:28. This is the video tape three.
BY MR. MITTELMARK:
Q. I think I needed to clarify my last question with you, Dr. Lopez. You don't recall any conversations with Dr. Tum on January 26, 2011 prior to the delivery of Heather McCants' child?
A. Correct.
Q. And had there been a concern on Dr. Tum's part after he rounded on Heather McCants as a patient on January 26th, based upon your custom and habit and experience with him cross-covering for you, you would have expected some type of communication, whether a phone call or an e-mail, a text or some -- somehow the two of you would have communicated?
A. Correct.
MR. SILVA: Object to the form. Asked and answered.
BY MR. MITTELMARK:
Q. Now -- Oh, thank you.
One of the things I think you spoke about is a biophysical profile. Could you describe for us what a biophysical profile is?
A. A biophysical profile is an ultrasound to evaluate parameters of an intrauterine pregnancy's well-being. It's made up of four elements that are

scored from zero to two using an ultrasound machine. The baby is evaluated for its movement, its breathing motions, its amniotic fluid and its tone. And the purpose of that test, it's one of the things that is a tool to help us determine whether the baby is in a stable environment or not.

Q. What I want to show you is a composite exhibit, which will be my next one, of the biophysical profiles that were performed on Heather McCants while she was a patient at St. Mary's Medical Center.

(Defendant's Composite Exhibit Number 8 was marked for identification.)

BY MR. MITTELMARK:

Q. I'd like you to take a look at those biophysical profile results, and then read into the record the one that was done on January 26, 2011.

A. Okay. I've now reviewed 12 biophysical profiles. The biophysical profile dated January 26, 2011 indicates that the single intrauterine fetus is noted to be in the vertex position. The fetal heart rate of 147 beats per minute is seen. Amniotic fluid index is noted to be 7.1. The placenta is in the anterior position.

Biophysical profile is performed. Two points are awarded for fetal breathing, fetal movement, fetal

tone, and qualitative amniotic fluid volume.

Biophysically score of 8 out of 8 points.

And this was read by Dr. Beckerman.

Q. And according to the biophysical profile report that you just read it's timed at, what is it, 1435 or 2:35 p.m.?

A. Correct.

Q. So this report was read by -- performed and read by -- was it Dr. Kellerman (sic), approximately one hour before Heather McCants was taken to the OB/OR?

A. Correct.

Q. Now, based on your review of the biophysical profiles, including the one for the date that Ms. McCants delivered her child, what do they tell you? Was there any change in that biophysical profile?

A. Well, as an ultrasound test for high-risk pregnancies, that means pregnancies have problems. You don't order a biophysical profile for a normal baby. You only order it for babies that have problems.

That this baby under its circumstances had sufficient fluid to be acceptable, sufficient movement to be acceptable, physician -- sufficient breathing motions to be acceptable, and physician -- sufficient fetal tone to be in an acceptable state.

And this is one of the tests that would --

would say that given whatever problems this baby comes to the table with, for what it has, what other risk factors are there, at least in fetal well-being for that moment it's -- it's doing as well as it can do.

Q. And we're talking as of 2:35 or approximately one hour before Ms. McCants was taken to the OB/OR?

A. Correct.

Q. So we know from your review of the progress notes and your review of the biophysical profile and your knowledge and history of this patient that as of at least 2:35 p.m. Heather McCants was in -- doing well?

A. Well, the baby is doing well for what it is. It's still a baby that is premature. It's a baby that has -- is living in an environment of a prolong rupture of membranes. It's a baby that has received not only antibiotics but has received steroids to help the lungs mature. It's a baby that's one pound -- you know, approximately two pounds at this point.

This is a baby who's under very serious surveillance. If it were a criminal, it would have a leg brace -- it would have an ankle bracelet. Okay. This is a kid that's under a lot of supervision.

And for the risk factors that this baby is carrying, it's doing as well as it could be doing for this point.

Q. So to clarify what I mean by doing well, is based on all of that supervision that has been ordered for this patient, including examinations by you, examinations by perinatologists, the nurses were doing their job and taking care of Heather McCants; would you agree?

MR. SILVA: Object -- object to the form.

THE WITNESS: Yes.

BY MR. MITTELMARK:

Q. At least as of up to 2:35 on January 26, 2011?

MR. SILVA: Object to the form.

THE WITNESS: Yes.

BY MR. MITTELMARK:

Q. So we know that Heather McCants had a PICC line. Do you know as you sit here why she was ordered to have a PICC line?

A. She was ordered to have a PICC line because she required to have a PICC line. There was an inability because of the physical characteristic of Mrs. McCants, her veins were not readily available to be cannulated for IV hydration, for medication administration.

And because she had been previous cesarean section and things can sometimes change rapidly, this is a patient who constantly needed a predictable, stable IV

access. So rather than making a human pincushion after her, in other words, sticking her till she's black and blue, a clinical decision was made that she is going to need to have an IV access that's called a PICC line.

A PICC line is ordered when it's necessary. It's a higher level of care than the normal typical patient would have. It's not something everybody gets. It's only those people that absolutely require it get.

And she was one of those people that had a requirement on the basis of her physical characteristics and the treatments that were administered to her that she needed to have IV access and PICC line was appropriate to be ordered for her.

Q. In this case, Heather McCants' case, the night before she delivered at 8:20 p.m. Dr. Stoessel wrote an order for Cathflo. That is not something you had anything to do with; am I correct?

A. That's correct.

Q. And I know you testified about your knowledge of Patrick Hare. You have experience at St. Mary's with the PICC Team, right, for your patients?

A. Yes, I have.

Q. So it wouldn't surprise you that Patrick Hare showed up on January 26th to take care or to fulfill Dr. Stoessel's order, right?

A. Correct.

Q. Okay. Now, as I understand your first involvement, and I'm going to use that word involvement, your first knowledge of Heather McCants needing some type of intervention by you was when you got a phone call?

A. Correct.

Q. And according to the testimony yesterday, the phone call was made and you answered right away. That's the type of physician you are, right?

A. Yes.

Q. And as soon as you got that phone call, you made a decision that you were going to come to St. Mary's Medical Center, right?

A. Yes.

Q. And there was no delay on your part, correct?

A. Correct.

MR. SILVA: Object to the form.

BY MR. MITTELMARK:

Q. Now, what happened prior to you getting that phone call, you have no knowledge, right?

A. Well --

Q. Let me ask it this way: And, again, prior to you getting that phone call, you had no knowledge of what was transpiring with Heather McCants as a patient?

A. Correct.

Q. And I'm sorry to rehash what you testified to in your first deposition, but can you tell us again what you recall about that phone call when you first heard about Heather McCants?

A. My response was that I identified that I was not in the hospital, that I would be on my way, and that she needed to be prepared for a cesarean section.

Q. Okay. Now, based upon your review of the records, would you agree that after the Cathflo was administered a rapid response was called?

A. Yes.

Q. And after the rapid response was called, the nurse taking care of the patient was in Heather McCants's room, Patrick Hare the PICC Team line -- PICC Team leader was in Heather McCants's room, Dr. Sanches an OB/GYN physician was in Heather McCants's room, Marilyn Wester, a labor and delivery nurse working on the antenatal floor was in Heather McCants's room, and Carol Seamon, the assistant supervisor that day, was in Heather McCants's room?

A. Correct.

Q. And that based on your experience, hopefully you don't have too much experience with Rapid Response Team, are appropriate personnel to respond to a rapid

response?

MR. SILVA: Object to the form.

THE WITNESS: Correct.

BY MR. MITTELMARK:

Q. And, additionally, we had a perinatal respiratory therapist, Luis Mosos. Do you know Luis Mosos?

A. Yes.

Q. Okay. So he also showed up. And you had a respiratory therapist by the name of Winthrop. Do you know who Neil Winthrop is?

A. Yes.

Q. So he's also showing up for the rapid response. And, again, these are appropriate personnel to take care of any issues if there is a respiratory arrest or respiratory distress, correct?

A. Yes.

MR. SILVA: Object to the form.

BY MR. MITTELMARK:

Q. Now, I know it is two-and-a-half years ago. Do you recall what Nurse Duckworth said about the fetal monitoring strips that she had reviewed on Dominic Shelton after the rapid response was called?

MR. SILVA: Object to the form. Assumes facts not in evidence. Misstates her testimony.

Go ahead.

THE WITNESS: While I don't recall independently every detail of what she told me, it was my understanding that the baby had undergone a prolonged deceleration.

BY MR. MITTELMARK:

Q. Okay. And what does that mean to you as a board certified OB/GYN physician?

A. It means that there has been a change in the fetal status from a heart rate that was normal to a heart rate that had decelerated below 80 beats per minute for more than two minutes and was ongoing.

This happens a lot. Especially in patients who are having low volumes of amniotic fluid that have had premature ruptures of membranes when sometimes the mother may change position and the baby inadvertently entangles itself in the umbilical cord.

And usually they're the things that the hospital has prearranged for nurses to be allowed to do which as a whole we call that body of maneuvers as intrauterine resuscitative measures would be to reposition the patient, to give the patient -- the mother oxygen, to increase the IV fluids on the patient, and, obviously, to alert all the other members of the medical staff.

All of these things were done by Nurse Duckworth. And the purpose of that is again hopefully by repositioning the patient, administering oxygen, increasing the amount of fluid volume, the overwhelming majority of these decelerations self-correct and the pregnancy continues.

In some cases they don't self-correct. And in those cases an emergent or an urgent delivery is performed after the intrauterine resuscitative efforts have failed for example.

Q. So I just want to be clear because I -- I think I understand. You don't recall if the rapid response was called at 3:12 and Michelle Duane, a nurse practitioner, shows up at 3:13; you don't know anything about the times that took place prior to your arrival at St. Mary's Medical Center?

MR. SILVA: Object to the form.

THE WITNESS: Correct.

BY MR. MITTELMARK:

Q. Now you talked about, or at least I talked about the fetal monitoring strips. And I know you testified earlier that you had reviewed them. What I would like to do is show you those fetal monitoring strips while Ms. McCants was in her room and immediately prior to and after the rapid response. And I would like

to get your opinion about what these fetal monitoring strips show. Is that okay?

A. Yes.

MR. SILVA: And on the record I'm going to -- I'm going to object to this entire line of questioning. The doctor has already testified that he did not review those fetal heart monitor strips prior to ordering the C-section. It's inappropriate for you to have him review them now after the fact.

MR. MITTELMARK: Objection overruled.

BY MR. MITTELMARK:

Q. Dr. Lopez, what I'm purporting to show you is fetal monitoring strips that were taken on Ms. McCants's fetus on January 26th prior to and shortly after the rapid response was called. And I would like you to just sit and look at them, and if you could tell us what they show to you.

And, again, fetal monitoring strips is something that you review as part of your performance of your OB/GYN duties, correct?

A. Yes. Starting with panel 75108, the fetal heart rate baseline is in the 150s. And there are some accelerations, which are signs that the baby is happy in the environment.

There is a couple of panels where it is uninterpretable. And what I mean by that is that the record doesn't indicate what the heart rate is actually doing during panel 75111 and 75112.

An interpretable panel is in 75113. And the heart rate shows acceleration to the 160s, which shows happiness on the part of the baby.

Then in panel 75115, which is just before 1430, there is a baseline in the 150s with an acceleration up to the 170s that would meet the 15-by-15 criteria of a reactive non-stress test.

That's followed by about two minutes of uninterpreted fetal heart rate pattern -- pattern.

Then on 75117 and 75118 the fetal heart rate appears to show multiple accelerations.

Panel 75119 fetal heart rate has accelerations with the baseline approximately 150.

Panel 75121 is reassuring. Meaning the baby appears to be in a stable, happy environment. Fetal heart rate's got a baseline of around 150, 155, has variability, has accelerations.

This continues in panel 75123 and 75124, panel 75125.

Panel 75126 again demonstrates a 15-by-15 acceleration indicating the baby is in a happy

acceptable environment.

Panel 75127 the fetal heart rate declines to the 90s, and then decelerates to below the 60s, and it stays in 75128.

It appears to be recorded perhaps at the 110 starting on panel 75129.

In 75130 it's going to 130 beats per minute and stays in the 130s until panel 75132 where you see the heart rate in the 150s.

And then the strip ends in one panel, 75133.

Q. So now having had an opportunity to look at what I'll call laser color copies of the fetal monitoring strips - and we'll go ahead and mark that as composite exhibit, whatever my next exhibit is - does that comport with your operative report and the discharge summary that you prepared on Heather McCants?

A. Yes.

(Defendant's Composite Exhibit Number 9 was marked for identification.)

BY MR. MITTELMARK:

Q. And going to your discharge summary, which I believe was marked as an exhibit. And I forget what Plaintiff's exhibit it was.

MS. WIDLANSKY: I have a marked copy --

MR. MITTELMARK: Oh, great.

MS. WIDLANSKY: -- I can show him.

MR. MITTELMARK: Thank you.

BY MR. MITTELMARK:

Q. Can you tell from that what happened to Ms. McCants after she delivered Dominic Shelton? Just the last few sentences.

And it's not a -- She was discharged right?

A. Yes. This is the discharge note. You know she underwent an emergency repeat C-section because of prolonged fetal deceleration and persistent fetal tachycardia under spinal anesthesia on 1/26/2011.

CT angio. revealed no evidence of acute pulmonary embolism. She remained hemodynamically stable.

And then she was discharged on prenatal vitamins, iron sulfate. She's not to have sex, not to lift, and her routine discharge instructions were given.

Q. Right. And you told us that the word emergency should be emergent?

A. Correct.

Q. And the word fetal tachycardia should be maternal tachycardia.

MR. SILVA: Object to the form.

BY MR. MITTELMARK:

Q. Right?

A. Yes.

Q. So based on your recollection of the delivery of Heather McCants's son Dominic Shelton in this case, was there anything out of the ordinary that occurred in the delivery room?

MR. SILVA: Object to the form.

THE WITNESS: No.

BY MR. MITTELMARK:

Q. And had something unusual or untoward happened in the delivery room, you most likely would have remembered that based on your career as a board certified OB/GYN physician who has delivered thousands if not tens of thousands of infants?

MR. SILVA: Object to the form.

THE WITNESS: Correct.

BY MR. MITTELMARK:

Q. So when you left according to the -- I forget what Plaintiff's exhibit it was. You left the delivery room at 4:15 -- Oh, I'm sorry. It was the access denied/granted and other badge events document.

So when you left the delivery room at 4:15 p.m. on January 26, 2011, as you sit here today can you remember what you were thinking about Heather McCants as a patient?

MR. SILVA: Object to the form.

THE WITNESS: Well, I had an ongoing concern because she had had a change in status with her heart rate going high and the possibility of her having a pulmonary event that could put her life in jeopardy.

But I was comforted in knowing that the hospitalist was taking charge of her, had ordered all of the testing to rule out those things that could have harmed Mrs. McCants, and had put her in special surveillance in the intensive care unit.

And, again, in the intensive care unit at St. Mary's, we're talking about a major trauma center. You get real good care. You get really good evaluations and really good care because it's a place where high-risk people frequently are brought to be cared for.

So while I had concerns also of her baby, because I knew her baby was less than -- You know, this is not a 7-pound baby. We're talking about a 2-pound baby, you know. We're not talking about a baby whose brains are ready to go or the lungs are ready to go and is going to be able to feed itself.

I knew that this baby was going to have a protracted battle, because I've taken care of other patients like Ms. McCants's baby. I've delivered

babies that had to be delivered prematurely.

But I felt that she had been appropriately cared for and informed about what was before her. Except for, you know, what was going on with her personally on the day of delivery.

BY MR. MITTELMARK:

Q. So when you left that delivery room on January 26, 2011, you knew that there was a mechanism in place for Ms. McCants to be seen by a pulmonologist, a maternal fetal medicine expert -- excuse me, physician, Dr. Deutsch that we talked about earlier, that she was going to get the VQ scan and the Doppler of the lower extremities, and that she was going to be in the ICU where she was going to be given one-to-one care, true?

MR. SILVA: Object. Object to the form.

THE WITNESS: Correct.

BY MR. MITTELMARK:

Q. And you knew from your presence in the delivery room that there was a board certified neonatologist Dr. Ambroise present, correct?

A. Yes.

Q. And that you had already ordered a neonatologist consult. So they were aware of the potential for having this child brought to their -- brought to the St. Mary's NICU, right?

A. Yes.

Q. And that Dominic Shelton, the infant that you delivered, was going to be taken not to anywhere other than the NICU at St. Mary's Medical Center, right?

A. Correct.

Q. So I have to ask you these questions, and I apologize for asking them. But when you treated Heather McCants from January 12, 2011 to January 26, 2011 when you delivered her son, did you have actual knowledge of the wrongfulness of your conduct and the high probability that injury or damage to Ms. McCants would result, and despite that knowledge you intentionally pursued a course of conduct that resulted in injury either to Ms. McCants or her infant, Dominic Shelton?

MS. WIDLANSKY: Form.

MR. SILVA: Object to the form.

THE WITNESS: No, I did not.

BY MR. MITTELMARK:

Q. And do you believe as you sit here today after having reviewed the St. Mary's Medical Center records on Heather McCants's January 26, 2011 admission that your conduct was so reckless that it constituted a conscious disregard or indifference to the life, safety or rights of Heather McCants or her infant son, Dominic Shelton?

MR. SILVA: Object to the form.

THE WITNESS: Absolutely not.

MR. MITTELMARK: Thank you, Dr. Lopez. I don't have anything further.

MR PUYA: Oh, do you have one there?

MR. MITTELMARK: I do.

CROSS-EXAMINATION

BY MR PUYA:

Q. Good afternoon, Dr. Lopez. Again my name is Keith Puya. I represent Dr. Lane. I just have a few questions for you, sir.

A. Okay.

Q. I appreciate your time.

The first question I'd like to ask you is as follows: Do you as the attending obstetrician, the obstetrician who delivered Dominic Shelton via cesarean section have any criticisms at all with respect to the type and administration of anesthesia that was provided to Ms. McCants in preparation for your surgery?

MR. SILVA: Object to the form.

THE WITNESS: No, I do not.

BY MR PUYA:

Q. Do you believe as the attending obstetrician preparing to deliver this baby that there was any delay in the performance of the cesarean section as a result

of anesthesia from your perspective?

MR. SILVA: Object to the form.

THE WITNESS: Absolutely not.

BY MR PUYA:

Q. From your observation, I heard you testify over the course of a couple of different sessions today, from your observation as the attending obstetrician is it your opinion that everyone involved as the team in getting Ms. McCants ready for this cesarean section acted appropriately, swiftly and as necessary to get this baby delivered as soon as possible?

MR. SILVA: Object to the form.

THE WITNESS: Yes.

BY MR PUYA:

Q. You told us before that this was an emergent or urgent C-section; was that your term?

A. Yes.

Q. Okay. Now let me ask you this: What was the actual indication for the cesarean section? In other words, was it -- was it the prolonged seven minute deceleration that the nurses noted following the issue regarding the Cathflo, or was it something else that led to your decision to ready Mrs. McCants for a cesarean section delivery?

A. It was that Mrs. McCants her heart rate went

into the 160s and 150s persistently beyond whatever event happened on the floor. And she had multiple risk factors for a possible pulmonary embolism.

In other words, one of the working diagnosis of why her heart rate would suddenly accelerate to double the normal rate is that a patient like Mrs. McCants who was 350 pounds, who had been bedridden for more than two weeks, who had had some sort of reaction to possibly some medication on the floor and whose heart rate had now accelerated to double normal was going to need to be thoroughly evaluated by tests that you kind of can't do when somebody is pregnant. You can't do a ventilation profusion scan for -- to determine her health, whether or not she had a clot. You know you can't do some of the better tests. She might have been physically too large to do a spiral CT exam. She may not fit in the machine.

And in order to maximize the safety of her, Ms. McCants, as well as her baby. Because her baby had had an intrauterine event that she -- that it appeared to be resuscitating from using the maneuvers that are standard. But it was about Mrs. McCants. She has in trouble. She was in a lot of trouble.

And we could be sitting here today talking about a completely different problem that involved

mostly Mrs. McCants had we not delivered her baby and done the testing and taken the precautions to ensure her health and well-being.

Q. So stated differently, please correct me if I'm misquoting you, that your reasoning for ordering an emergent or urgent cesarean section dealt primarily with your concerns about Mrs. McCants.

MR. SILVA: Object to the form.

BY MR PUYA:

Q. Is that a fair statement?

A. Correct.

Q. Not to disregard the well-being of the fetus, but your primary concern when you received that phone call when you were at this -- the other hospital down the street about what had happened to Mrs. McCants, your reasoning for making the decision to ready her for a cesarean section was based upon what happened to her and your concerns about her well-being and physical status.

MR. SILVA: Object to the form.

MS. WIDLANSKY: Form.

BY MR PUYA:

Q. Is that a fair statement?

MR. BLOOM: Join.

THE WITNESS: Yes.

BY MR PUYA:

Q. Now, did you understand that Mrs. McCants, and I'm going just to make sure I understand this, do you believe that she had a respiratory arrest or that she had respiratory failure?

MR. SILVA: Object to the form.

BY MR PUYA:

Q. Or is there a difference in your mind, and if there is, tell me if there is, please.

A. For all intents and purposes to me they were the same. She had an event, a respiratory event. Some may have described it one way. Others who were closer to her may have described her in a different way. But in either event, she had an event.

Q. And that event, if you will, affected her hemodynamics, did it not?

A. Oh, yes.

Q. Okay.

A. It affected her hemodynamics to the point that an experienced nurse who carries -- who cares for patients in a career-wide basis set -- set the alarm for the rapid response and for as much supportive care as could possibly be mustered to attend to her patient's care.

Q. Did you conclude or did you know rather in

talking to -- Was it Nurse Duckworth who actually spoke with you over the phone?

A. Yes.

Q. That there had been evidence on the fetal monitor tracings of some period of decelerations with respect to the fetal heart rate?

A. Not before the Cathflo, but afterwards, yes.

Q. Concomitant with the event regarding the Cathflo --

A. Correct.

Q. -- fair enough?

And that wouldn't be an unexpected finding, however? If the mother, maternal blood flow or the maternal system is being affected it could carry over into the fetal system too; could it not?

A. Correct. And you can see this from something as benign a process as the mother rolls flat on her back or that the mother passes out and lands on her back or that the mother repossessions herself on -- you know, flat on her back.

But the mother has -- You know, among the physical characteristics of the mother is that she weighs 300 plus pounds. And that weight comes and compresses on the uterus and possibly the umbilical cord was somewhere in proximity of where the baby's body

would compress it.

Q. And you -- Obviously you've before January 26th of 2011 have probably performed, I'll let you give me the number, but no doubt a significant number of cesarean sections; is that a fair statement?

A. Yes.

Q. And many of those and, unfortunately, probably a fair number of those have been under emergent or urgent situations?

A. Yes.

Q. Have you in the past been comfortable using a spinal anesthesia in that setting?

A. Yes, in many --

MS. WIDLANSKY: Form.

THE WITNESS: When it's indicated --

MR. SILVA: Object to the form.

THE WITNESS: -- a spinal -- spinal should be used.

BY MR PUYA:

Q. Okay. And that's a safe and effective alternative to general anesthesia --

MR. SILVA: Object --

BY MR PUYA:

Q. -- and certainly would allow you to conduct your cesarean section as needed.

MR. SILVA: Form.
BY MR PUYA:
Q. True?
MS. WIDLANSKY: Join.
THE WITNESS: Yes.
BY MR PUYA:
Q. So in this particular case you're not critical or you don't fault Dr. Lane for administering the subarachnoid block or the spinal anesthesia to ready Mrs. McCants for your surgery, do you?
A. No.
MR. SILVA: Form.
BY MR PUYA:
Q. And you're note suggesting to us or to this jury if this is read that the anesthesia in any way delayed your performance of the cesarean section, are you?
A. No.
MR. SILVA: Object to the form.
BY MR PUYA:
Q. Did you happen to -- I mean you saw the baby when you delivered the baby. I think last time you told us -- I think you used the word -- I don't know if it Superman or the baby looked pretty good?
A. The baby ways a rock star.

Q. A rock star. I mean you've been involved -- And, again, don't take this negatively. But you've been involved I'm sure in cases where the outcome hasn't been very good upon delivery?

A. That's correct. I've been involved where babies are in real trouble, and I've been involved in cases where babies didn't make it.

Q. So you have a benchmark. I mean you have a knowledge base where you've seen that outcome in which to compare this case to?

MR. SILVA: Object to the form.

THE WITNESS: Yes.

BY MR PUYA:

Q. Okay. So with that being said, was there anything that suggested to you when you delivered Dominic Shelton, took him out of the womb and handed him to the neonatal personnel that there was any suggestion or thought to you that this baby was suffering from some hypoxic ischemic event?

MR. SILVA: Object to the form.

THE WITNESS: Absolutely not. By the national standards that we use, if you're going to use Apgar scores below five at five minutes indicates a baby in trouble.

This baby had a score of eight at one minute

and a eight at five minutes. This baby was surrounded by a high-risk pediatric neonatologist, a respiratory therapist, and possibly another nurse at the time of delivery that they all looked at the baby, and they said the baby looks great. The baby was crying. The baby was wiggling, moving around and kicking.

Now, we knew -- Look, we knew what we were dealing with. Babies at 27 weeks, babies at 2 pounds are not like 40-week baby's, full-term babies. They're not like 7 pound, 8 pound babies like Ms. -- or not like 8-pound babies like Ms. McCants had had previously.

This is a baby whose brain wasn't ready. It's lungs wasn't ready. It's GI tract wasn't ready. And it had a long, hard trip ahead of itself.

But as far as how it was when it was born, there was zero evidence of an asphyxiated baby. It doesn't meet the national standards; doesn't meet the local standards.

BY MR PUYA:

Q. So relatively speaking here given the gestational age of 27 weeks and a few days, this baby's Apgar scores in your mind were certainly not consistent with any type of hypoxic ischemic event; is that a fair

statement?

MR. SILVA: Object to the form.

THE WITNESS: Yes.

BY MR PUYA:

Q. And you mentioned to us before, was the baby getting surfactant? Was the baby getting some type of steroid for lung maturation?

A. Before the baby was born, this baby received two doses of steroids to accelerate fetal lung maturity as is appropriate in someone -- as is appropriate in a baby who is thought to be at risk of being born before the lungs were going to be ready.

Also received several courses of the appropriate antibiotic to protect it from the ravages of a possible infection in light of the fact that her (sic) mother's bag of water broke and was broken for a long time.

Q. You mentioned to us Mrs. McCants' body habitus. I think you said that she was close to or in excess of 350 pounds?

A. That's correct.

Now, look, I'm a big guy. I'm not -- I'm not making any judgments about people's sizes. I'm a big guy. Big people carry big risk.

Q. And you mentioned too about having to tape her

panniculus, the weight or the fat, if you will, that drapes over the surgical site?

A. That's right.

Q. What other things that you could tell us need to be done in order to ready her for surgery in order to conduct a safe procedure, not only for the mother, of course, which was your primary concern it sounds like, but also for the well-being of the baby?

A. Well, we all recognize from experience that it was 3:00 in the afternoon. It's after lunchtime at St. Mary's. Now it's -- Lunch at St. Mary's doesn't show up at 12:00. It might show up at 1:00; it might show up 1:30, but it shows up. And before Ms. McCants had her event, she had had lunch. Now, how much lunch she had had, I didn't personal know. But I know that she had completed her lunch.

I had seen Ms. McCants physically. Like I said, I'm a big person myself. Ms. McCants had a lot of physical features that have to be taken into consideration before she has surgery. She's a -- She's 350 pounds or so. She has a neck that's short. Now, I'm not -- Again, I'm not trying to say that that's -- that's a bad thing. It just is what it is.

And we certainly already knew that Ms. McCants was in trouble. Her heart rate was already twice what

the rate it was supposed to be.

If she was car, like I said, on a highway, instead of going 55, she's going 110. And she had been going 110 for a little while here. To the point where we needed to get her delivered and get her stable. And we certainly didn't need to go out of our way to make more troubles for Ms. McCants. So the important things that were needed to be done were taken into consideration.

Now, about her stomach, okay, she had a big stomach, not because her baby was full term. She had a big stomach because she had a big stomach. And that gut when you lay them down to do an operation on is going to sit on their stomach. So if there is something on their stomach, you've got to be careful that you have protected that patient's airway. You do not want this patient to die from aspiration, from vomiting or suffocation or other issues that may be related to a short neck, a full stomach and a big gut.

So among mature, experienced obstetricians and anesthesiologists, the form of anesthesia I expected her to have was a spinal. She just ate. She's big. You don't need any more trouble than you already had on the table.

And so I had absolutely no issue with

Dr. Lane's decision to proceed with a subarachnoid anesthesia.

Q. Okay. The last question I have, and just you seem very passionate about what you do; is that a fair statement?

A. I love what I do. I feel honored to have been able to be a physician, to have been able to be of service not only to our community but throughout a big chunk of the State of Florida over a very long period of time I might add - same thing for Dr. Tum - and be part of a team of people that do this often.

Q. And I guess my point really is you seem to me to be the type of person that if you were not happy with what was being done or you felt things weren't being done as quick as you wanted them, as quick as Dr. Berto Lopez wanted things being done for your patient, are you the type of person that speaks up and lets people know that, you know, you want things done differently?

MR. SILVA: Object to the form.

THE WITNESS: Oh, absolutely. I'm not -- I'm not a shrinking violet. If things weren't right, people would have heard about it. That didn't happen here.

Everybody did exactly what they were supposed

to do in a professional and timely manner. And these shadows and wild -- wild accusations, they're not going to hold up.

MR PUYA: Thank you very much, Dr. Lopez. I appreciate your time.

MR. BLOOM: I have one question.

MR. SILVA: Go ahead.

MR. BLOOM: Thank you.

CROSS-EXAMINATION

BY MR. BLOOM:

Q. Good afternoon, Dr. Lopez.

A. Good afternoon.

Q. I represent Dr. Sanches as you may know. I think Mr. Puya sort of roundabout asked the question I'm going to ask. Do you have any criticisms of any of the actions that Dr. Sanches took on January the 26th?

A. No.

MR. SILVA: Object to the form.

MR. BLOOM: Thank you.

MS. WIDLANSKY: Next? Any questions?

MR. SILVA: Yes, I have some questions for you.

REDIRECT EXAMINATION

BY MR. SILVA:

Q. When you initially applied for privileges at

this hospital, what did you have to do?

A. I had to --

MS. WIDLANSKY: Form. Outside the scope.

Go ahead.

BY MR. SILVA:

Q. Go ahead.

A. I had to fill out paperwork indicating my knowledge, training and experience, detailing my knowledge, training and experience, give references, gives logs of previous experience for the privileges that I had been requesting, and to fill out a delineation of privileges page, which indicated that I wanted to be an obstetrician/gynecologist.

Q. And you had to do that specifically for this hospital, St. Mary's Medical Center?

A. For each of the hospitals. It's a lot boilerplate, the same.

Q. Do you have privileges at Bethesda?

A. No, I do not.

Q. Have you ever applied at Bethesda Hospital --

A. No.

Q. -- for privileges?

A. No, I haven't.

Q. Are you familiar with their staff bylaws at Bethesda?

MS. WIDLANSKY: Object to form.
THE WITNESS: No.
BY MR. SILVA:
Q. Are you familiar with the policies and procedures for the medical staff at Bethesda Hospital?
MS. WIDLANSKY: Form.
THE WITNESS: No, I'm not.
BY MR. SILVA:
Q. Okay. Are you familiar with the medical staff bylaws at St. Mary's Medical Center?
A. Yes.
Q. Are those medical staff bylaws created by St. Mary's Medical Center that require physicians to conduct themselves in a certain situation so that they can see their patients and take care of their patients at this -- at this hospital?
MS. WIDLANSKY: Form.
THE WITNESS: Yes.
BY MR. SILVA:
Q. Okay. And does St. Mary's also require of their physicians that have privileges like yourself, admitting privileges and surgical privileges that you abide by St. Mary's Medical Center's policies and procedures?
MS. WIDLANSKY: Form. Asked and answered.

Outside the scope of cross.
BY MR. SILVA:
Q. You can answer.
A. Yes.
Q. The -- I think Mr. Mittelmark was asking you earlier you were consulted to take care of Heather McCants by Dr. Stoessel?
A. I believe it was in part by Dr. Stoessel, correct.
Q. Okay. Now, had you ever taken care of Heather McCants prior to her being admitted to St. Mary's Medical Center?
A. I don't think so, no.
Q. Okay. You never took care of her prior two births that she had?
A. Correct.
Q. Okay. Were you aware that the two births that she had prior to this were C-sections?
A. Yes.
Q. So this baby was going to be required to be delivered by C-section regardless of the prenatal outcome, correct?
A. Yes.
MS. WIDLANSKY: Form.

BY MR. SILVA:

Q. Why?

A. Because she had multiple risk factors. Having had two previous cesarean sections, she was at a greater risk of a uterine rupture than someone had had a single cesarean section.

Additionally, at various times through her hospitalization, her baby was not always head down. Sometimes it was sideways. Sometimes it was I believe -- I mean I may not be a hundred percent correct, but it was in a position other than head down, vertex.

Q. Do you know if St. -- if St. Mary's Medical Center requires a neonatology consult for all patients that are to have a C-section?

A. I don't know. I do know that they are -- neonatologists are present at every delivery or they're proxies, meaning a nurse practitioner or...

Q. Has a nurse practitioner or a neonatologist always been present at your C-section deliveries at St. Mary's Medical Center?

A. Yes.

Q. And so you would have expected a neonatologist or nurse practitioner to be present at the delivery of Heather McCants' baby on January 26, 2011,

correct?

A. Yes.

Q. I think you testified earlier that you take all comers to St. Mary's Medical Center, right?

A. Yes.

Q. And that's because you have privileges at this hospital, right?

MR. MITTELMARK: Object to the form.

THE WITNESS: That's one of the reasons, but there are others.

BY MR. SILVA:

Q. Okay. Do you take all comers to Bethesda Hospital in Palm Beach County?

A. I don't go to Bethesda.

Q. Okay. So you can't take any admissions at Bethesda because you don't have privileges there, correct?

A. Correct.

Q. But you can take all comers to this hospital because you have privileges at this hospital?

A. Correct. To a point, but there are other reasons.

Q. Okay. Did St. Mary's privilege you for -- privilege you for any specific or special privileges when you initially obtained privileges there?

MS. WIDLANSKY: Form.

THE WITNESS: No.

BY MR. SILVA:

Q. Have you obtained any additional privileges over the years at St. Mary's?

A. Only in those areas where technology has evolved, for example, laser, carbon dioxide laser, possibly some of the new advancements in surgeries where you have to have documentation of experience.

Q. Okay. You're not a board certified neonatologist, are you?

A. No.

Q. You're not a board certified maternal fetal specialist, are you?

A. No.

Q. Are you a board certified maternal medicine physician?

A. No.

Q. Have you ever been a hospitalist at a hospital before?

A. For internal medicine, no.

Q. Yes. Are you a board certified cardiologist?

A. No.

Q. Board certified pulmonologist?

A. No.

Q. When Heather McCants came into the hospital at St. Mary's, she was initially put on broad spectrum intravenous antibiotics?

A. Yes.

Q. And then those were discontinued because she was showing no signs of the infection; isn't that true?

A. Correct. And the course that would be a treatment for the beta strep that she did have evidence of infection of had been completed.

Q. Right. And that's -- that's a finding in pregnant women, beta strep, and that's treated with antibiotics?

A. Yes.

Q. And that's to prevent any transfer of the strep to the baby during the birth of the -- of the fetus?

A. Well, except in this case where her water was broken. So she had lost before she came to St. Mary's her -- She was at risk for intrauterine infection because one of the natural barriers to prevent an infection of her baby wasn't in place. Her amniotic sac had been ruptured. And that put her at much greater risk of having a baby that was going to be harmed by any infection that could have occurred in the vagina.

Q. Put her at risk. But just because someone is

at risk doesn't mean it's going to happen, correct?

A. That's correct.

Q. Okay. And, in fact, there was a surgical pathology performed on Heather McCants' placenta after birth; do you recall that?

A. Yes.

Q. Okay. I'm going to hand you this document, which I'm going to mark as Plaintiff's Exhibit Number 24.

(Plaintiff's Exhibit Number 24 was marked for identification.)

BY MR. SILVA:

Q. And what were the results of that pathological review of her placenta after birth?

A. Under the final diagnosis it said early third trimester placenta with a three vessel umbilical cord showing no specific histopathologic alteration.

Q. Okay. Is there a diagnosis of chorioamnionitis on that form?

A. No.

Q. Okay. What is chorioamnionitis?

A. It's an infection of the membranes of the gestational sac.

Q. Okay. You also mentioned that she had a positive AFP?

A. Yes.
Q. Okay. What does AFP stand for?
A. Alpha-fetoprotein test.
Q. Okay. What is that test performed for?
A. The presence of an extra amount of a protein product in the mother's circulatory system that could signal one of many problems with the baby.

One of the problems might be an opening or a hole in the baby's spine. That's called spina bifida. That can cause the release of the alpha-fetoprotein from the baby's system to the amniotic fluid through the placenta into the mother's system. That's one possibility.

Q. You're talking about a neural tube defect?
A. That's correct.
Q. Did this baby have a neural tube defect?
A. I did not follow up on all the problems that this baby had. This baby had a lot of problems. But -- but I don't know --
Q. Do you know if this baby had a neural tube defect?
A. I do not know. And there are other people that can speak to what the baby had. But I do not know that it did.
Q. Do you know as you sit here today if this

child has a diagnosis of spina bifida?

A. I -- I do not know.

Q. Okay. Now, Mr. Mittelmark asked you a long line of questioning about when Heather McCants came into this hospital, St. Mary's, her baby's health continued to do well in the womb prior to the Cathflo incident; do you agree with that?

A. To -- to -- Well, only to the degree that a biophysical profile shows that the baby is stable. It doesn't -- doesn't take into account that the membranes have been ruptured. It doesn't take into account that the mother had been carrying a bacteria infection in the vagina. It doesn't take into account that the mother had a white count of 30,000 before she was transferred. It doesn't take into account that this -- this mother's alpha-fetoprotein test, which not only looks for neural tube defects, but is also a marker for something wrong with the baby.

And, you know, from your presentation, I understand that the baby has a very small head and some other problems that it can be a marker for. So as I understand it this is -- this is a baby that, yes, the biophysical profiles were eight out of eight. They are not perfect for every single scenario: It doesn't talk about the amniotic fluid; it doesn't talk about

infection; it doesn't talk about positive AFP; it doesn't talk about prematurity and the immature brain, lungs and digestive system. So as -- as a test within its limitations, it was fine.

Q. So all of the biophysical profiles were normal. I think you counted 12 or 13?

A. I don't recall the exact number, but we could recount them.

Q. That's fine. Twelve or thirteen, they were all normal?

A. They were all eight out of eight, correct.

Q. Okay. Eight out of eight is a perfect score, isn't it?

A. For what it's limited scope of evaluation, yes.

Q. Is there anything based upon the biophysical profile -- all the biophysical profiles prior to the Cathflo incident in this case that led you to conclude that you needed to deliver this baby early?

A. No.

Q. Did you conclude that this child needed to be delivered early because the mother had chorioamnionitis?

A. No.

Q. Did you conclude that this baby needed to be delivered early because there was a maternal infection?

A. No.
Q. Did you conclude that this baby needed to be delivered early because the mother had a high heart rate?
A. Yes.
Q. Prior to the Cathflo --
A. Oh, no. I'm sorry.
Q. -- incident. Yeah.
A. I'm sorry.
Q. Okay. So prior to the Cathflo incident, you never concluded that this mother needed to have her baby delivered because she had a high heart rate, correct?
A. Correct.
Q. Did you conclude that the mother, Heather McCants, needed to have her baby delivered early prior to the Cathflo incident because she had a positive alpha-fetoprotein?
A. No.
Q. I think that Mr. Mittelmark did a very good job of pointing out that approximately one hour prior to the Cathflo incident this child had a biophysical profile that was eight out of eight, correct?
A. Yes.
Q. And that was performed by Dr. Tum?
A. It was ordered by -- Probably I think the

original order may have originated with Dr. -- Dr. Stoessel. The performance of the test is by an ultrasonographer. And it was inter -- it was then interpreted by a radiologist, and the report was generated.

Q. Okay. And that biophysical profile approximately one hour prior to the Cathflo incident on January 26, 2011 was normal, or eight out of eight?

A. Correct. So that -- that criteria of a potential trigger for delivery did not indicate delivery had to happen.

Q. And that's my next question. Based upon your experience as a board certified OB/GYN -- How many years have you been practicing?

A. I've been in private practice since 1987.

Q. 1987. Since -- You've been in practice since 1987, how many babies or fetuses have you taken care of where the mother had premature ruptured membranes?

A. Hundreds.

Q. Hundreds. And what is your goal when a mother has a premature ruptured membrane with regards to how long you want to have the baby stay in the womb?

A. That's a complex answer. Let me start it this way: Depending on how far along the pregnancy is, there are certain goals that you have. You want to -- You

have to first take into consideration the status of the mother. If the mother -- if the mother dies, the baby dies. Okay?

So if the mother's life is at risk because she's had cardiopulmonary arrest or she's had a car accident and she's bleeding profusely, you have to deliver the baby if it's viable no matter what. You can't -- You know, you got to deliver, when you got to deliver in those -- in that type of an emergency.

Then you have those situations where the mother has medical problems: Maybe she's a diabetic; maybe she failed a sugar test; maybe she has high blood pressure; maybe her heart runs fast; maybe she's big; maybe she's obese; maybe she's morbidly obese; maybe she has other medical problems.

You want to stabilize those as much as you can so that the atmosphere where the baby's growing is -- is stable.

Now as to the baby, the baby is another unit. You know, is the bag of water broken or not broken. If it's broken, you look for signs of infection. If the baby is early, premature, you want -- you want to help accelerate the development of the brain, the lungs and the intestines for as long as you can.

Now, there is some medicines we can give while

the baby is still inside like steroids, dexamethasone or betamethasone to allow the baby to have a better chance of its lungs working.

There's some medications that -- like antibiotics that if the baby might be exposed to an infected environment that the antibiotics will kill the bacteria to the point where you can't see it by looking at a piece of the placenta. You're going to keep an eye on the mother again to make sure she doesn't have a fever or uterine tenderness.

But you want to get the baby as big as you can get it before it has to be delivered either vaginally or by C-section.

Q. Okay.

MR PUYA: Excuse me. I don't mean to interrupt you. I've got a 1:30 hearing. Can we take a five minute, ten minute break? I've got a status conference with the judge.

MR. SILVA: Oh, yeah. You can do it by phone?

MR PUYA: Yeah. He's going to let me do it by phone --

MR. SILVA: Okay. Sure.

MR PUYA: -- next door.

MR. SILVA: So a five minute break?

MR PUYA: Well, it's 1:26. So I think it's a

ten minute case management conference so...

THE VIDEOGRAPHER: Off the video record 1:26.

(A recess was taken.)

MR. SILVA: We have been instructed to continue without Mr. Puya.

THE VIDEOGRAPHER: We're now back on the video record at 1:48.

BY MR. SILVA:

Q. Doctor, you're not an anesthesiologist, are you?

A. No.

Q. You're not a board certified anesthesiologist?

A. No.

Q. You're not board certified in neuroradiology?

A. No.

Q. How about rehabilitation medicine?

A. No.

Q. Are you board certified as a geneticist?

A. No.

Q. Now, you mentioned earlier AFP. Besides a neural tube defect, what else can that indicate?

A. It can indicate -- It has been noted to be a marker of adverse perinatal outcomes.

Q. What does that mean?

A. Including preterm ruptured membranes. You

know a test that if it comes out positive, you know, you look for the things that it's the most sensitive and specific to. For example, you do a level 2 ultrasound to see if you can detect a large or a medium sized neural tube defect. But it's not going to -- You know, an ultrasound isn't going to catch a small neural tube defect.

But that pregnancy is a high-risk pregnancy if you have a positive alpha-fetoprotein test. It could also be a marker for unusual chromosomal abnormalities and unusual morphological abnormalities of a real small head or small neck and shoulders.

Q. What else?

A. Well, the list is exhaustive. I'm sure some expert will be telling you the what else later.

Q. Have you ever done any type of research on what an abnormal AFP result can result in?

A. Only to satisfy my own curiosity, not related -- not in regards to this case.

Q. In your practice what do you use AFP for?

A. Well, we do it as a screen for neural tube defects, premature labor and as a marker for high-risk pregnancies.

Q. Okay. Did this mother have premature labor?

A. Yes.

Q. She was in labor?
A. She had contractions, yes.
Q. Where?
A. I believe in Indian River. That's one of the reasons they sent her. Her white count was 30,000. She was hydrated. I mean not -- Did she dilate and progress in labor, no.
Q. What's the definition of labor?
A. Progressive cervical dilation and effacement.
Q. Was this woman in labor when she arrived at St. Mary's Medical Center?
A. No, she was not.
Q. Okay. So as far as you know, Ms. McCants was never in labor at St. Mary's Medical Center, correct?
A. Correct.
Q. And I think you've already told us you don't know if this child has ever had a diagnosis of a neural tube defect after birth, do you?
A. No.
Q. Now, if this child didn't have the Cathflo incident that required the delivery at 27 weeks, ideally how long would you have wanted this child to stay in the womb?
A. I guess the general answer is as long as possible all other things being normal.

Q. Okay. But let's -- let's assume that she was continuing to be monitored in the hospital. Would you have allowed -- allowed her baby to mature to 38 weeks of gestation, or would have taken him -- taken him by C-section prior to that?

MR. MITTELMARK: Objection to the form.

THE WITNESS: In general because of the stress of the preterm ruptured membranes, the fetal lung maturity was accelerated, the standard for a normal pregnancy would be you would do a repeat C-section at 39 weeks.

And patients with preterm ruptured membranes, we would actually collect fluid from the mother, if fluid was available to be gotten then either by amniocentesis or by -- by collection, having her sit on a bedpan and letting amniotic fluid fall out.

And when maturity was recognized. So it could have been as early as 35 weeks, or it could be as late as 39 weeks.

BY MR. SILVA:

Q. Okay. Would you -- In a patient who has premature ruptured membranes and has no other indication for an earlier C-section, is there any time that you would take a baby before 35 weeks?

A. Yes. Sometimes, you know, when they get four-and-a-half pounds. Sometimes if there are other maternal or fetal indications for involvement.

Q. Okay.

A. If it's not growing, you know, like gaining weight by ultrasounds. If it's not -- If other markers of -- of well-being aren't met.

Q. If Heather McCants had continued to remain stable, would you have kept her in the hospital or would you have sent her home?

A. No. She would have remained hospitalized till delivery.

Q. Okay. Even if her alpha-fetoprotein, AFI increased?

A. Okay. They're two different things. AFI is amniotic fluid index to me.

Q. That's what I meant, AFI.

A. All right. If the -- If it appeared that the mother sealed and was no longer leaking and the amniotic fluid was in the normal range, under certain circumstances patients could be released.

The specific problem with where Ms. McCants lived and worked was that the nearest Level 3 hospital was St. Mary's, and it's quite a ways away. So, you know, you have to balance the risk and the benefits of

early premature discharge or the consequences of a delivery requiring transport of a premature baby.

Q. Okay.

A. So some discussion and some calculus has to be made in terms of what's best for the baby and the mother.

Q. What kind of an AFI would you look for, for example, in Heather McCants before you would say, okay, I'm going to release her let's say to a family member's house in West Palm Beach?

A. Well, in some places if it was say more than ten consistently for a long period of time and no evidence of infection.

Q. So your plan on this patient prior to the Cathflo incident that caused changes with the mother and the baby was to continue to monitor her in the hospital until the time that the baby could be safely delivered?

A. Correct. Had clinical evidence of fetal lung maturity, weight of greater than four-and-a-half pounds, the absence of other indicators for delivering.

Q. How would you determine this fetus's clinical lung maturity?

A. By obtaining a sample of amniotic fluid either by amniocentesis, which is where we stick the needle into the intrauterine cavity and extract it or by

collection by having the mother sit on a bedpan and allow amniotic fluid to be collected and submitted for evaluation.

Q. Okay. And when -- when you take that sample of amniotic fluid say from the bedpan, what kind of test do you run on it to determine the fetal lung maturity?

A. L/S and -- L/S ratio and PG. Although at some point we rolled over into something called laminar body studies, which is a product -- a protein product that is in a sufficient quantity in babies whose lungs are mature.

Q. That's the laminar body studies?

A. Correct.

Q. And is that a routine test that you can perform at the hospital at St. Mary's?

A. Yes. I mean I can't speak to whether it's actually performed at the hospital or sent out to a reference lab.

Q. Right. But you can order it at the hospital?

A. You can order it. Yes, it's something we do often.

Q. Did you guys ever order a laminar body study --

A. No.

Q. -- prior to the Cathflo incident?

A. No.

Q. Do you have any expert opinions as an anesthesiologist for the care rendered by Dr. Lane?

A. No.

Q. What would you have done differently as far as monitoring Heather McCants' baby if she continued in the hospital prior to the Cathflo incident that required her early delivery?

MR. MITTELMARK: Object to the form.

BY MR. SILVA:

Q. You can answer.

A. I'm not sure I completely understand what you're asking.

Q. Yeah. Well, you agree that the reason that this baby was delivered at 27 weeks is because she had a reaction to Cathflo, the mother and the baby had a reaction to that incident, to that event?

A. Do I agree with that? I think the mother had persistent maternal tachycardia in the 160s and 150s the basis of which was not clear.

It happened acutely on the same day that she had a reaction to Cathflo in proximity to a reaction to Cathflo.

The baby, on the other hand, had a deceleration that could be explained in many different

ways but appeared to be recovering so...

Q. And is that the reason that you did the C-section?

A. Yes.

Q. Okay. Now, if the mother's heart rate was 125 knowing that she had a history of tachycardia, would you have performed a C-section based upon that information alone?

A. No.

Q. I'm going to hand you Plaintiff's Exhibit Number 12, which is the Rapid Response Team Worksheet.

Can you tell me what the mother's heart rate was recorded at?

A. 125.

Q. Okay. Knowing what you knew about Heather McCants and her history of tachycardia, would you have performed a C-section on her that day on January 26, 2011 for a heart rate of 125?

MR. MITTELMARK: Object to the form.

MS. WIDLANSKY: Form.

MR PUYA: Join.

THE WITNESS: Without an evaluation, no. Evaluation for fever, for infection, or would have had an internal medicine consult to take a look to see what the possible causes were.

But, obviously, it deteriorated from 125 to the 150s to 160s, which is dramatic. It was already abnormal. Now its going to be, like I said, twice normal.

BY MR. SILVA:

Q. Well, didn't you order the -- the C-section at the time of the Rapid Response Team call?

A. I ordered preparation for a C-section, yes.

Q. Okay. That's when you ordered the C-section, right?

A. That's when I ordered the preparation for C-section, correct.

Q. Okay. And what was Heather McCants' heart rate at that time?

A. Well, it depends. You're just pointing to --

Q. Take a look at the documents.

A. Yeah, I see that. But there was -- There were more measurements. You know, what you're negating is whatever information Nurse Duckworth presented to me at the time of the phone call, which was after this.

Q. There are more measurements. There's actually a strip there. Tell us what her heart rate was there.

A. There's a strip here. Okay.

Q. Tell us what the heart rate was on the strip.

A. 116.

Q. Okay. It was actually lower than 125, wasn't it?

A. When the strip was run, yes.

Q. Okay. When was that strip run?

A. I can't exactly read the time, but I'll be open to -- If you could point to me a legible time.

Q. Yeah. Let me take a look.

I don't see a time.

A. Okay.

Q. Is this strip attached to the Rapid Response Team Worksheet?

A. Yes.

Q. Okay. And what is the maternal heart rate on that strip?

MS. WIDLANSKY: Form.

THE WITNESS: 116.

BY MR. SILVA:

Q. Okay. Did you base your decision to perform a C-section on Heather McCants on January 26, 2011 based upon the heart rate of 116 --

MS. WIDLANSKY: Form.

THE WITNESS: No.

BY MR. SILVA:

Q. -- alone?

A. I based it on an increase from 116 to 125 to

129 at 1519 to 150 and 160 sometime thereafter.

Q. Well, by the time it was 150 and 160, you had already called a C-section, right?

A. Yes. Preparation for C-section, correct.

Q. Preparation for C-section means you called a C-section, didn't you?

A. Preparation for C-section is preparation for a cesarean section.

Q. Okay. And you told the nurses, and the nurses advised the rest of the operating room staff to prepare the patient for C-section --

A. Correct.

Q. -- correct?

And you performed that C-section?

A. I did because she -- her heart rate was even higher.

Q. Right.

A. And that indicated to me a deteriorating maternal status. Like I said, if I didn't inter -- if I didn't intervene, would we be -- would we be here today talking about a totally different problem this time with Ms. McCants?

Q. Well, you had to do what you did to intervene, didn't you?

A. Yes, and I did.

Q. Okay. You did your job, right?
A. Yes.
Q. Now, I want you to show me where in the medical records the mother's heart rate is -- prior to her C-section where it is 160. Prior to the C-section.
A. In the anesthesia record?
Q. In the anesthesia record.
A. Uh-huh.
Q. Yes.
A. That's prior to her C-section. She has the spinal in, and the heart rate graph looks something that if she were a car, she'd be running twice normal rate.
Q. Twice normal rate. What was her normal rate, 120?
MS. WIDLANSKY: Form.
THE WITNESS: What day?
BY MR. SILVA:
Q. What was her normal heart rate?
A. What day?
Q. How about on -- when she was admitted?
A. Okay. I have a heart rate of 116, a heart rate of 112, a heart rate of 93, a heart rate of 90. I'm just going to give these to you.
Let's make this an exhibit.
Q. No, you don't get to mark exhibits.

A. Oh, I don't? Okay. Well, then here. Let me give it to you.

Q. Unless you want to go to law school.

A. No, sir. I just want you to get this information as quickly as possible.

Q. Just tell me.

A. Well, it's recorded as vital signs. The 17th of January at 1730 it's record as 116. But on January --

Q. 116?

A. Yeah. January the 18th it's 90 and 93.

Q. Okay. So 116 times two, what is that?

A. Sir --

Q. 240?

A. Yeah.

Q. You're telling me that her heart rate was twice her normal heart rate, and that's the reason that you did the C-section.

Was her heart rate ever 240 anywhere in these medical records? Show me where her heart rate was 240.

A. No.

MS. WIDLANSKY: Form.

BY MR. SILVA:

Q. Can you show me that?

A. No. I said twice normal, not twice her rate.

So you're confusing two things.

Q. Well, what's -- what's her normal rate?

(Mr. Puya entered the room.)

THE WITNESS: Well, like I said, one day here --

BY MR. SILVA:

Q. We're not talking about some fantasy patient. We're talking about Heather McCants.

A. Right.

MS. WIDLANSKY: Form.

MR. BLOOM: Join.

BY MR. SILVA:

Q. What's her normal heart rate?

A. Well, what date do you want it to be? What date do you want me to tell you her pulse, and I will tell you.

Q. Didn't you tell me it was 116 on her admission --

A. Yes.

Q. -- one of the readings?

A. Yes, on one reading.

Q. Okay. Did you discount that reading, or do you think it was falsely entered by the -- by the nurses?

MR. MITTELMARK: Object to the form.

MS. WIDLANSKY: Form.
MR PUYA: Form.
THE WITNESS: I'm sorry. Could you repeat that question?
BY MR. SILVA:
Q. Did you discount the reading of 116 beats per minute on admission, or did you think that was falsely entered by the nurses?
MR. MITTELMARK: Object to the form.
MS. WIDLANSKY: Join.
MR PUYA: Join.
THE WITNESS: Neither.
BY MR. SILVA:
Q. Now, once you told me, just a few minutes ago, that one of the other reasons that you decided to do the C-section on Heather McCants is because she had a heart rate in the 160s in the operating room; is that what you said?
A. And I'm going to point that to you if I may.
Q. I would like you to.
A. Okay. Let me see Plaintiff's exhibits --
Q. Are you looking at -- for the anesthesia record?
A. Yeah.
Q. Okay. Here it is.

A. Here we go.
Q. It's Plaintiff's Exhibit Number 19.
A. Okay.
Q. Tell us what the patient's heart rate was on that form.
A. 160. 160. Looks like a couple 160s. 155 maybe.
Q. Do you see a vital sign entry there on that anesthesia note?
A. I see many of them.
Q. Look at the vital sign entry.
A. Okay. Let's make sure we're both looking at the same thing.
Q. Yeah.
A. You're talking about here where it says pulse 129?
Q. Well, does this say pulse 129?
A. That's what it says.
Q. Right?
A. Yes.
Q. Okay.
A. Which is different than one oh -- 100, and it's different than 116.
Q. And it's all --
A. But -- And we can agree --

Q. It's different.
A. -- that all the pulses here are higher than or equal to 150.
Q. And it's different from 160, isn't it?
A. And it's different from what she had on the 17th the through one hun -- through -- Wow, even after her surgery.
Q. Are you looking at these check marks here?
A. No. I'm looking at the dots. It's the dots that are pulse.
Q. You know that that is her blood pressure, right?
MS. WIDLANSKY: Form.
THE WITNESS: Yes. Yeah. But do you see these dots?
BY MR. SILVA:
Q. Do you know how to read an anesthesia record?
A. Yes.
Q. Are you an anesthesiologist?
A. No.
Q. Okay.
A. No. I'm an experienced OB/GYN that reads a lot of records.
Q. Okay. And do you disagree that the pulse as noted on the vital sign portion there is 29?

A. No. And it's abnormal.
Q. You agree with that, right?
A. That's what it says.
Q. Okay. And didn't you look at the pulse on admission and just tell me a little while ago that it was 116?
A. Yes.
Q. Do you consider the difference between 116 and 129 statistically different -- significant?
A. In a patient who had acute shortness of breath, and let me see what else was recorded on your -- on that note that we were talking about.
I mean you're not asking me to ignore it, are you? I mean I certainly wouldn't ignore it, because then I would be -- like I said, we'd be here for a totally different problem.
Q. I'm ask -- I'm asking you do you a consider a pulse on admission of 116 and then a pulse of 129 in the operating room statistically significant?
A. Yes.
Q. This difference?
A. Yes, because --
Q. You do?
A. Yes. Because not just on the pulse alone, because I'm not treating a pulse. I'm treating a human

being.

And the pulse is one of many measures. And if you take the history of what this patient I was told had happened, and which you pointed out, on January 26th at 1516 the rapid response note page two says the patient had shortness of breathe with chest pain.

Now, you're not asking me to ignore that, are you?

Q. Are you looking at --

A. And -- Listen.

Q. Do you have --

A. And --

Q. Are you asking me a question?

A. No, I'm telling you the answer. The answer is I'm treating --

Q. What's -- What was my question?

MS. WIDLANSKY: Let him --

BY MR. SILVA:

Q. What was my question?

A. Go ahead and please read the question.

MS. WIDLANSKY: Let's him finish.

BY MR. SILVA:

Q. You don't -- you don't get to make a speech. You have to answer my questions.

MS. WIDLANSKY: He is answering your question.

You're interrupting him.

MR. SILVA: Repeat the question so he understands what he has to answer.

(The question was read by the reporter.)

MR. SILVA: Statistically significant.

THE WITNESS: Different, yes.

BY MR. SILVA:

Q. Thank you. Now, you testified earlier the reason that you decided to perform this C-section is because Heather McCants had an abnormally -- she was at a very high rate, twice her -- the double heart rate, and that's the reason you needed to perform the C-section.

And do you recall just going over her heart rate on admission being 116, and in the operating room being 129; do you recall that?

A. You have mischaracterized what I stated. You can ask the court reporter to repeat my answer. Her pulse was twice that of a normal person.

It is still a significant change from her own baseline. And if you take into consideration her clinical picture if we are to believe the rapid response where she had chest pain and shortness of breath and now has tachycardia more than her usual, a prudent physician would evaluate this patient for a pulmonary embolism.

Q. Do you know if the person who decided that she had tachycardia knew that she had a history of tachycardia prior to admission at St. Mary's?

A. Yes, that was me.

Q. That was you?

A. Right.

Q. Okay.

A. And it's recorded in my history and physical.

Q. And you considered -- Did you consider the baby to have tachycardia, fetal tachycardia?

A. When?

Q. At any point in time prior to the delivery?

A. Any time there is greater than 160, yes.

Q. Okay. So you also thought that the baby had tachycardia?

A. I didn't think that. I knew that.

Q. Okay. Did the baby have a heart rate double what you would expect in a baby?

A. Now you're saying things and testimony that I've never said.

Q. No. I'm asking you. It's a question.

A. Yeah. The question is I don't know what you mean by that.

Q. Did --

A. Where did you -- where did you get the idea

that that was said?

Q. Did you think -- I'm asking you do you think that the baby had a heart rate twice the normal heart rate when you said the baby had fetal tachycardia?

Do you understand my question?

A. No. Repeat it.

MR. SILVA: Okay. Repeat it court reporter.

(The question was read by the reporter.)

THE WITNESS: No.

BY MR. SILVA:

Q. No what?

A. No, I don't understand your question. A normal fetal heart rate can be as high as 160.

Q. Okay. Can -- can a fetal heart rate ever be 240?

A. Yes.

Q. Can it be 280?

A. Yes.

Q. Okay. Did this baby have an fetal heart rate of 240?

A. No.

Q. Did this baby have a fetal heart rate of 280?

A. No.

THE VIDEOGRAPHER: We need to go off record to change tape real fast.

MR. SILVA: Okay. Go ahead.

THE VIDEOGRAPHER: Off the video record at 2:13.

(A recess was taken, and the proceedings were continued in Volume II.)